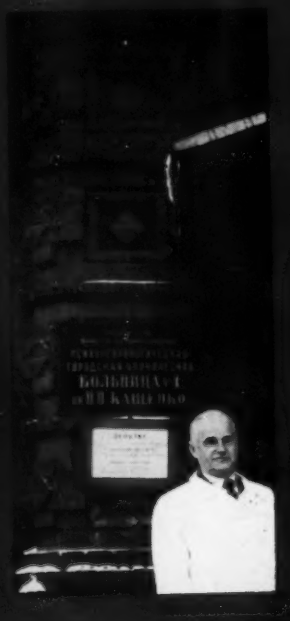
Mental Hospitals

August 1961

Hospital Journal
of the American Psychiatric Association



WORK THERAPY in the Soviet Union

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THIS
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Volume 12 Number 8

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Mental Hospitals *Hospital Journal of the*

AMERICAN PSYCHIATRIC ASSOCIATION

Contents, August 1961

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PSYCHIATRIC PRESCRIBING INFORMATION

INDICATIONS: 'Stelazine' relieves anxiety, whether expressed as hyperactivity or as apathy. It also produces rapid response in many diagnostic categories, including acute and chronic schizophrenias, manic-depressive psychoses, involutional psychoses, chronic brain syndrome and mental deficiency.

ADMINISTRATION AND DOSAGE: Dosage of 'Stelazine' should be adjusted to the needs of the individual.

Because of the inherent long action of 'Stelazine', patients may be controlled on convenient b.i.d. administration; some patients, on once-a-day administration.

Adult Dosage for Use in Psychiatric Practice

oral (for office patients and outpatients with anxiety): The usual starting dosage is 1 mg. or 2 mg. b.i.d. In the treatment of these patients, it is seldom necessary to exceed 4 mg. a day. (Some patients with more severe disturbances, and discharged mental patients, may require higher dosages.) In some patients, maintenance dosage can be reduced to once-a-day administration.

oral (for patients who are either hospitalized or under adequate supervision): The usual starting dosage is 2 mg. to 5 mg. b.i.d. (Small or emaciated patients should always be started on the lower dosage.)

The majority of patients will show optimum response on 15 mg. or 20 mg. daily, although a few may require 40 mg. a day or more. It is important to give doses that are high enough for long enough periods of time—especially in chronic patients.

Optimum therapeutic dosage levels should be reached within two or three weeks after the start of therapy. When maximum therapeutic response is achieved, dosage may be reduced gradually to a satisfactory maintenance level.

intramuscular (for prompt control of severe symptoms): The usual dosage is 1 mg. to 2 mg. (½-1 cc.) by deep intramuscular injection q4-6h, p.r.n. More than 6 mg. within 24 hours is rarely necessary. As soon as a satisfactory response is observed, oral medication should be substituted at the same dosage level or slightly higher.

Only in very exceptional cases should intramuscular dosage exceed 10 mg. within 24 hours. Since 'Stelazine' has a relatively long duration of action, injections should not be given at intervals of less than 4 hours because of the possibility of an excessive cumulative effect.

'Stelazine' Injection has been exceptionally well tolerated; there is little, if any, pain and irritation at the site of injection.

Dosage for Psychotic and Mentally Defective Children

The dosages given below apply to children, ages 6 to 12, who are either hospitalized or under adequate supervision.

oral: The starting dosage is 1 mg. administered once a day or b.i.d., depending on the size of the child. Dosage may be increased gradually until symptoms are controlled or until side effects become troublesome. Both the rate and the amount of dosage increases should be carefully adjusted to the size of the child and the severity of the symptoms, and the lowest effective dosage should always be used. Once control is achieved, it is usually possible to reduce dosage to a satisfactory maintenance level.

In most cases, it is not necessary to exceed 15 mg. of 'Stelazine' daily. However, some older children with severe symptoms may require, and be able to tolerate, higher dosages.

intramuscular: There has been little experience with the use of 'Stelazine' Injection in children. However, if it is necessary to achieve rapid control of severe symptoms, 1 mg. (½ cc.) of 'Stelazine' may be administered intramuscularly once or twice a day, depending on the size of the child. Once control is achieved, usually after the first day, the oral dosage forms of 'Stelazine' should be substituted for the Injection.

SIDE EFFECTS: *In the dosage range of 2-4 mg. daily,* side effects from 'Stelazine' are infrequent. When they do occur, they are usually slight and transitory. Mild drowsiness occurs in a small percentage of patients; this usually disappears after a day or two of 'Stelazine' therapy. There are occasional cases of dizziness, mild skin reaction, dry mouth, insomnia and fatigue; rarely, neuromuscular reactions (extrapyramidal symptoms).

In hospitalized psychiatric patients receiving daily 'Stelazine' dosages of 10 mg. or more, clinical experience has shown that, when side effects occur, their appearance is usually restricted to the first two or three weeks of therapy. After this initial period, they appear infrequently, even in the course of prolonged therapy. Termination of 'Stelazine' therapy because of side effects is rarely necessary.

Side effects observed include dizziness, muscular weakness, extrapyramidal symptoms, anorexia, rash, lactation and blurred vision. Drowsiness has occurred, but has been transient, usually disappearing in a day or two.

Extrapyramidal Symptoms

These symptoms are seen in a significant number of hospitalized mental patients receiving 'Stelazine'. They may be characterized by akathisia, be of the dystonic type, or they may resemble parkinsonism.

akathisia: Some patients may experience an initial transient period of stimulation or

jitteriness, chiefly characterized by motor restlessness and sometimes insomnia. These patients should be reassured that this effect is temporary and will disappear spontaneously. The dosage of 'Stelazine' should not be increased while these side effects are present.

If this turbulent phase becomes too troublesome, the symptoms can be controlled by a reduction of dosage or the concomitant administration of phenobarbital or some other barbiturate.

dystonias: These symptoms are rare outside of mental hospitals, but they may be observed occasionally in patients who have received 'Stelazine' as a mild tranquilizer.

Symptoms may include: spasm of the neck muscles, sometimes progressing to torticollis; extensor rigidity of back muscles, sometimes progressing to opisthotonos; carpopedal spasm, trismus, swallowing difficulty, oculogyric crisis and protrusion of the tongue.

The onset of the dystonias may be sudden. A primary characteristic of these symptoms is their intermittency. They may last several minutes, disappear and then recur. There is typically no loss of consciousness and definite prodromata are usually present. Initially, these intermittent symptoms occur in a crescendo of intensity. Then as the effect of the drug wears off, the intervals between the occurrence of symptoms become longer, and the intensity of the symptoms subsides. Despite their similarity to symptoms of serious neurological disorders, these dystonias are usually promptly reversible and need not cause undue alarm. They usually subside gradually within a few hours, and almost always within 24 to 48 hours, after the drug has been temporarily discontinued.

Treatment is symptomatic and conservative. *In mild cases*, reassurance of the patient is often sufficient therapy. Barbiturates are also useful. *In moderate cases*, barbiturates will usually bring rapid relief. The dosage and route of administration of the barbiturate used should be determined by the intensity of the symptoms and the response of the patient. *In more severe adult cases*, the administration of an anti-parkinsonism agent produces rapid, often dramatic, reversal of symptoms. Also, intravenous caffeine and sodium benzoate seems to be an effective and rapid antagonist to the dystonias. *In children*, reassurance and barbiturates will usually control symptoms. Dosage and route of administration should be determined according to the intensity of symptoms and response of patient.

Note: It has been reported that injectable administration of Benadryl* may also be helpful in controlling dystonias.

pseudo-parkinsonism: These symptoms are extremely rare outside of mental hospitals. Symptoms include: mask-like facies; drooling; tremors; pillrolling motion; and shuffling gait.

Reassurance and sedation are important components of effective therapy. In the majority of cases these symptoms are readily reversible when an anti-parkinsonism agent is administered concomitantly with 'Stelazine'. Occasionally it is necessary to lower the dosage or to temporarily discontinue the drug.

CAUTIONS: Clinical experience has demonstrated that 'Stelazine', a phenothiazine derivative, has a wide range of safety and that there is little likelihood of either blood or liver toxicity. The physician should be aware, however, of their possible occurrence.

One of the results of 'Stelazine' therapy may be an increase in mental and physical activity. In some patients, this effect may not be desired. For example, although 'Stelazine' has relieved anxiety and, at the same time, anginal pain in patients with angina pectoris, a few such patients have complained of increased pain while taking 'Stelazine'. Therefore, if 'Stelazine' is used in angina patients, they should be observed carefully and, if an unfavorable response is noted, the drug should be withdrawn.

Hypotension has not been a problem, but nevertheless adequate precautions should be taken when the drug is used in patients with impaired cardiovascular systems.

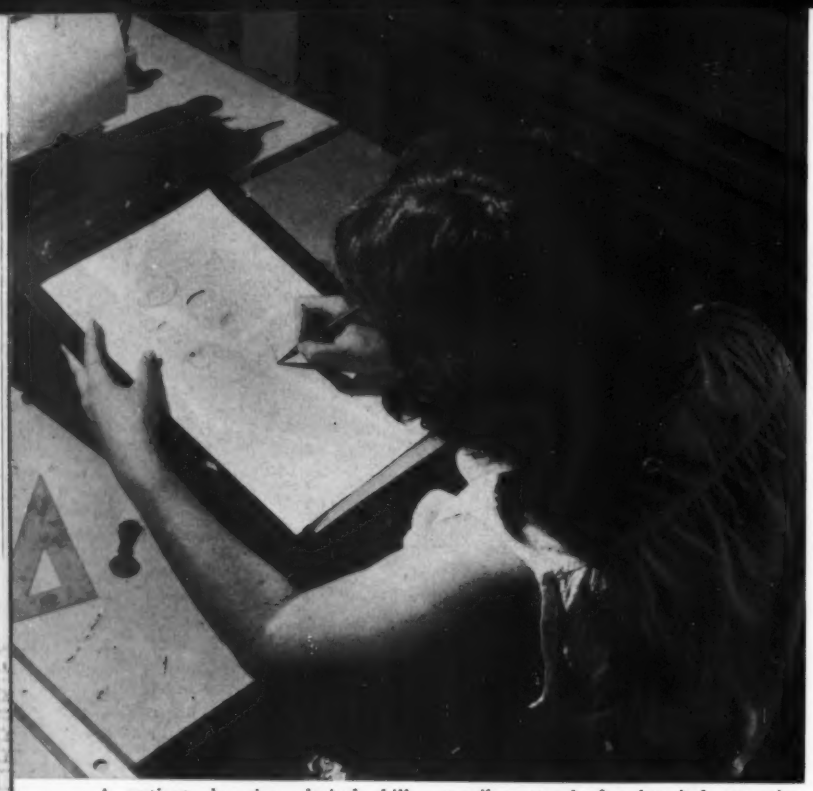
The antiemetic action of 'Stelazine' may mask signs of overdosage of toxic drugs or may obscure the diagnosis of conditions such as intestinal obstruction and brain tumor.

Although 'Stelazine' has shown very little potentiating activity, caution should be observed when it is used in large doses in conjunction with sedatives or depressants.

CONTRAINDICATIONS: 'Stelazine' is contraindicated in comatose or greatly depressed states due to central nervous system depressants.

AVAILABLE: Tablets, 1 mg. and 2 mg., in bottles of 50, 500 and 5000. (Each tablet contains 1 mg. or 2 mg. of trifluoperazine, as the dihydrochloride.) Also available, for psychiatric patients who are hospitalized or under close supervision: **Tablets,** 5 mg. and 10 mg., in bottles of 50, 1500 and 5000. (Each tablet contains 5 mg. or 10 mg. of trifluoperazine, as the dihydrochloride.) **Injection,** 10 cc. Multiple-dose Vials (2 mg./cc.), in boxes of 1 and 20. (Each cc. contains, in aqueous solution, 2 mg. of trifluoperazine, as the dihydrochloride, 4.75 mg. of sodium tartrate, 11.6 mg. of sodium biphosphate, 0.3 mg. of sodium saccharin, and 0.75% of benzyl alcohol, as preservative.) **Concentrate** (for hospital use), 2 fl. oz. bottles (10 mg./cc.), in boxes of 4 and 12. (Each cc. contains 10 mg. of trifluoperazine, as the dihydrochloride.)

*Trademark Reg. U.S. Pat. Off.: 'Benadryl' for diphenhydramine hydrochloride, Parke-Davis.



A patient, learning clerical skills, stencils artwork for hospital magazine.

Mental Illness and Vocational Handicap

*By HAROLD R. MARTIN, M.D. and IRVING J. SCHAEFER

THE VOCATIONAL REHABILITATION of a mental patient is sometimes questioned on the ground that it represents an attempt to force upon him the goals and standards of others. Critics suggest that this is in contrast to and in conflict with the aims of therapy, their presumption being that a therapist strives to bring out the patient's uncensored and unmodified personality. Even if it were possible, we question the desirability of completely excluding standards and goals in therapy.

To our knowledge, no constructively functioning man has ever lived who was not part of a culture and a social structure. Most patients share common goals and standards—often not apparent superficially—with other members of society. There is, for instance, the patient who is convinced he is a burden and a liability, but who shows signs of an enhanced self-concept when he is presented with evidence that he is useful—when we ask him to help us do a job or enable him to earn a paycheck from a sheltered workshop. He stands a little taller and holds his head a little higher when he finishes this work, indicating that to be a "useful human being" is an inherent need in us all.

Among the populations of large psychiatric hospitals there are many patients who have recovered from their original disabling illness, but who are still unable to make the transition back to the community. Cumming states that "historically, rehabilitation of the physically ill began when we started to give attention to our failures. . . . Paradoxically, the rehabilitation of the mentally ill is the opposite. . . . It is most important with those patients with whom we have been therapeutically successful."[1] If it is true that the need for psychiatric rehabilitation is for patients who have recovered or partially recovered from their illness, the questions arise: "What is the handicap?" "How is the patient's function impaired if he has 'recovered' from his psychiatric illness?"

Even though the disabling symptoms of his psychiatric illness may have been removed or controlled, the patient must make a transition, overcoming both internal and external resistances before he can again share with others the pursuit of a full and meaningful life. This transition is the business of rehabilitation. Even if the patient retains little or no residual handicap from his illness, the fact that he has been ill has interrupted the continuity of his functioning within society, making him a displaced person. Nor is his hospitalization the only source of the difficulty. The displacement is primarily one of attitudes and expec-

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[1]*Cumming, J.: Rehabilitation of the Mentally Ill, American Association for the Advancement of Science, Washington, D.C., 1959, p. 113.*

tations. Even if he has made an excellent adjustment for a long period of time, his illness is likely to be uppermost in the minds of members of his family and community. His family may have closed ranks, no longer regarding him as a father, brother, or husband, but as a patient. The community, including his former or potential employer, may no longer regard him as a machinist, clerk, or attorney, but as a patient. Most important of all, he regards himself as a patient.

Making the Uphill Grade

At best, moving through the various phases of life is an uphill process, but for those who have stayed on the path, the way ahead is clear. They may proceed naturally from childhood through adolescence, maturity and middle age to old age, or from school to employment through maximum productivity to retirement. But the man whose last residence was the mental hospital, whose work record is a report of his hospital adjustment, is no longer on the highway that leads naturally to participation in the work of the world.

The vocational rehabilitation counselor represents the community and its demands for realistic decisions and adult relationships. In the light cast by the counselor's constructively critical attitude, the patient may test his first stumbling attempts to solve the real problems of his transition before he faces the less forgiving community. The counselor must recognize that the patient's insecurity and fear are, at least in part, realistic, and work primarily with what assets the patient has that can be used to solve the real problems he faces.

On a practical level the counselor serves as a source of factual information concerning the availability of and requirements for various jobs, a liaison with community rehabilitation resources for both the patient and the hospital, and an evaluator and developer of the patient's vocational potentials. Development through training is a practical step toward employment, and helps the patient to think of himself not only as *having* something more in the way of a specific skill, but also of *being* something more. He can approach an employer as a barber, a beautician, a bookkeeper, or a secretary—not just a patient.

While the counselor does not say to the patient, as does the therapist, "Show me your weaknesses," but says, "Show me your strengths," his understanding of the patient's total personality, including the illness, is his most important tool. Thus his two-way communication with the psychiatrist and other members of the treatment team cannot be overemphasized if he is to function constructively. Formal and written reports are necessary for administrative reasons and for records, but as a means of communication they are a poor substitute for personal contact and discussion.

If a counselor reacts punitively to a patient's hostile defensiveness or unwittingly encourages a passive-dependent way of life, the fault is likely to be with the communication system between him and those who are professionally able to understand and predict such symptomatology. In order to adapt his approach to the patient's needs, the counselor must understand something of the dynamic processes that will mold this individual's relationships, first with him and later with the community. A patient's potential and his psychopathology may indicate that the optimal goal of therapy and rehabilitation for him will be a continuing passive-dependent adaptation. In such a case, the counselor may find a job for the patient, take him to his first day's work, and continue to maintain a supportive relationship with him.

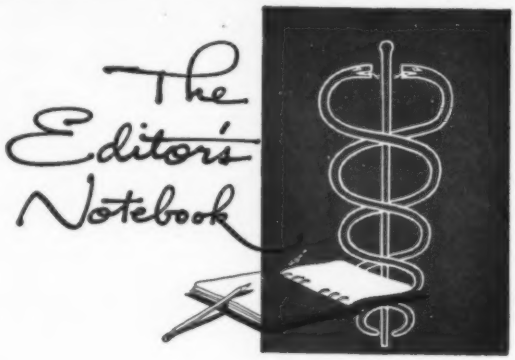
Another patient may be capable of making his own job application and of developing his own employee-employer relationship. In this case, the counselor need only give factual information and perhaps help the patient with a role-playing session in anticipation of the job interview. In some instances, the patient's right not to work at all must be accepted and respected.

Counseling with Honesty

The counselor, when he contacts an employer about hiring a patient, should present an honest evaluation of the patient's work potential and any appropriate information relative to his illness. He may solicit the employer's understanding, but should not expect him to make special concessions for the individual he has hired. Above all, the counselor must not make the employer feel that he is being asked to take over the responsibilities of the counselor or the doctor. In the eyes of the man who hires him, the patient is an employee and must carry his own weight and earn his pay. It is up to the psychiatric team to be responsible for residual symptoms of the illness (or a relapse) which prevents the ex-patient from functioning effectively on the job.

In contrast to work with the physically disabled, the relationship of the rehabilitation counselor with a psychiatric patient is usually more important than are tangible services. Giving things to or doing things for the patient have value only as a *part* of a constructive interpersonal relationship. Without an awareness of these factors, "services" can be more disabling than enabling.

At best, the psychiatrist's ability to predict his patient's success or failure in making a social or vocational adjustment is limited. Since initial success in terms of either continued employment or type of employment is hardly more predictable than it is in the lives of the rest of us, initial failure or false starts can be expected more as the rule than as the exception. Many patients have never really failed in anything—except life. An overwhelming fear of failure has paralyzed their capacity to attempt anything if failure is a possibility. If they can come to realize that should they fail at first, they are still acceptable to the counselor who will help them to try again, they may be able to accept the idea that initial failure and ultimate disaster are not synonymous.



IT IS IMPOSSIBLE TO WRITE a job description for today's psychiatrist; the demands upon him are too varied and multifold. He is expected to treat – and, hopefully, to cure – both acutely and chronically ill patients. He attempts to "do research" in the wistful hope of the "great breakthrough" or, in more personal and human terms, to be able to answer the question, "What makes him act like this, doctor?" And finally, he strives to perpetuate his own skills, not only by training the coming generation of psychiatrists, but also by sharing the psychiatric mysteries with nurses, social workers, psychologists, activity therapists, and the many others concerned with helping the mentally ill.

Small wonder, then, that he sometimes takes refuge in activism, trying to do too much for too many people, trying to meet impossible demands. By so doing, he isolates himself from the mainstream of humanity because this is the only way he can hope to do all of the things he thinks he should. He becomes less than a fellow human being, less than a doctor – merely an executive who, from a pinnacle, directs the activities of others.

Sammy must stop running and take time out for thought. He has some painful facts to face – one being that his specialty has suffered a degree of fallout from the stigma attached to those queer, rather unpleasant people he has elected to treat. Since the families and friends of psychotic patients often "can't stand them any longer," it follows naturally that anybody who actually chooses to spend his professional life with them must be tarred of the same brush – after all, "birds of a feather flock together." This notion is reflected in all sorts of folk-names – "headshrinker," "trick cyclist" (an ingenious inverted onomatopoeia of World War II), "nut doctor," and the rest.

Psychiatrists may not be particularly sensitive to such name-calling, but if it is true that the public images of psychiatrists and their patients are mutually dependent, then it is time we went to work to dispel the hocus-pocus and bring ourselves back into focus as ordinary men, as physicians, as specialists whose skills are directed toward a group of diseases which afflict a large number of our fellow citizens. The more people see us in our primary role of physician, the more they will see our patients in their primary role of "sick people."

Perhaps because the psychiatrist deals with the intangibles of human experience – fear, love, hatred, aspiration, anger – the public also tends to invest him with a certain mysticism, an almost priestly role. He is expected to have opinions about mental hygiene, child guidance, education, religion – even about space travel and the hydrogen bomb. Such grandiosities are tempting, of course. But if he is to meet the genuine needs and not the ignorant demands of his community, the psychiatrist's primary responsibility is to devote himself to the holy triad of all medicine – treatment, training, and research.

How is he to do this? It was once suggested that "the individual is the primary unit of administration. He must guide his own activities with some degree of direction and orderliness."[1]

In many respects, the hospital psychiatrist is in the vanguard of this type of self-administration. Out of sheer pressure of work, he has learned to differentiate vital needs from unrealistic demands. He has learned to contribute profitably as a consultant to those who work more intensively with individual patients, discovering at the same time when his own intervention is essential. From this experience he learns and in a broad sense fulfills one of his "research" obligations. As the leader of the team, he teaches by sharing his knowledge. He also shares the daily struggles of the ward personnel, the social workers, the activity therapists, and the patients themselves for clarification, for comfort, for constructive behavior. Nobody sees him as odd, aloof, an odd-ball. He's a combat officer in the war against mental illness.

Hospital patients and personnel have a highly realistic picture of the psychiatrist. He is one of their fellow workers, whose special competence is an essential part of the operation. The hospital psychiatrist is uniquely qualified, therefore, to communicate this picture to his fellow physicians, be they general practitioners, psychiatrists, or other specialists; whether they are working in private practice, in general hospitals, in community health centers, in universities or medical schools. Today's ward psychiatrist—the leader of tomorrow—possesses the leaven essential to improve the reputation and the usefulness of his specialty.

Matthew Ross, M.D.

[1] *Blain, Daniel: Hospital Administration and the Medical Superintendent, Mental Hospitals, 8:6:6-11, June 1957.*

Hospital Vocational Rehabilitation

By ALFRED K. BAUR, M.D.
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SPECIFIC, PLANNED PROGRAMS of vocational counseling and rehabilitation in mental hospitals are of relatively recent origin, especially in state hospitals. They have been spurred along by the increased interest of state offices of vocational rehabilitation in the vocational problems of mental hospital patients. Therefore, hospital directors of rehabilitation programs have been screening out patients who had vocational problems and were well enough to be referred to the state OVR for placement either in a job or in a job-training situation.

But it is too late to begin vocational assessment and counseling for patients who are sufficiently recovered to be considered "feasible" for the OVR. A more logical approach is to train a patient for a vocation and have him work at it, if possible, while he is still in the hospital. Such work tests a patient's ability and gives him specific experience.

Believing in this approach, we encouraged our industrial therapy staff to work closely with the vocational rehabilitation staff so that a patient's vocational evaluation and planning would begin much earlier in his convalescent period. The industrial therapist and the vocational rehabilitation specialist soon realized that their programs were intimately related. Therefore, we placed the industrial therapy section under the administration of the vocational rehabilitation director rather than under the coordinator of activity therapies. In this way, we could diagnose a patient's vocational problem as soon after admission as possible and give him immediate assistance.

We went through a similar process in developing social service functions. At one time, we employed social workers mainly to record histories and to help get patients out of the hospital *after* their physicians decided their degree of recovery warranted plans for discharge. Here, too, we were "too late in the day" for effective planning and action. Now it is routine for our social workers to be involved in intake of patients, to determine *then* whether there will be a problem about returning patients to their homes when they recover, and how to keep the family-patient relationship intact during the patients' hospitalization. In other words, discharge planning starts when a patient is admitted to the hospital.

Likewise, we begin vocational rehabilitation on admission. If a new patient has a vocational problem, his physician takes this fact into consideration throughout the course of therapy. As soon as the patient's condition warrants it, we make a vocational evaluation and assessment and define his vocational objective. Then we give the patient an industrial assignment related to this.

Types of Vocational Problems

We discovered several types of vocational problems among hospitalized mental patients: (1) patients who successfully pursued a vocation prior to their illness, but need help either to retain skills or brush up on them; (2) patients (particularly adolescents) who have never been trained in any specific skill, but who may have a capacity for training; (3) patients who, for some reason, were not suited to their vocations or need to be trained in another type of work because residuals of their mental disorders make return to their previous type of work impossible; (4) patients with poor prognoses for discharge who, nonetheless, need vocational activity—the rehabilitation concept includes bringing every patient up to his maximum level of possible adjustment even if he remains hospitalized.

Vocational training, as a link in the chain of rehabilitation, is severely limited in our hospital because we lack shops and personnel for specialized work. However, it is possible for us to give vocational training in certain areas. For example, our beauty shop is approved by the State Cosmetology Board to

train patients as beauty operators. So far, one patient has been trained and has passed the state boards. We also instruct certain patients in how to care for other patients in our infirmaries and acute medical and surgical units. Several of these patients have been able to contribute to their own support by working in nursing homes.

In connection with our educational program, we assigned three patients to industrial therapy as a "typing pool" to do selected jobs for various hospital departments. We also assign patients for training in maintenance, but, unfortunately, this requires our regular maintenance employees to take time from their work, which we can ill afford to have them do. Our chief use of the maintenance department in rehabilitation has been to test a patient's aptitude in a specific field and evaluate his work habits before recommending him for return to employment.

Rehabilitation's Hopeful Results

Some of our patients also receive training in the hospital bakery and kitchen. In fact, the kitchen is our "training and testing ground" from which patients are selected to work in the kitchen of a local college. In September 1959, we made an agreement with the college catering service for our patients to work in its kitchen under the supervision of the manager of the food service and the regular employees. Fifty-one patients have participated in this program since its inception; 13, for various reasons, could not make the adjustment, but 23 were discharged from the hospital and are employed outside. Of the latter, 4 have returned to the hospital.

When a patient demonstrates his ability to work and assumes some responsibilities in industrial therapy, he may "graduate" to our newly developed sheltered workshop. Here, we attempt to simulate actual working conditions; we record the patient's time and output and pay him accordingly out of receipts from contracts with outside businesses. In this way, the patient is able to earn money which he may need to support himself before he receives his first pay check after he leaves the hospital.

At present, we have several contracts for stuffing and addressing advertising literature for mail-order companies. We also have set up a shop for repairing wooden cases for soft drinks. In this shop, we can evaluate a patient's capacity to produce, the quality of his production, how he operates under pressure and with fellow "employees," and how he takes supervision from the "boss" of the workshop. We hope to use these evaluations as recommendations to future employers.

A few patients have been able to obtain local employment, working outside and sleeping in the hospital until they can save enough to afford quarters in the community. They live on a special rehabilitation ward which is being developed as a kind of half-way house. A half-time rehabilitation specialist works with this ward and is slowly increasing the patients' responsibility for self-care and management.

Some sort of half-way house is necessary for many patients as a final step in putting them completely on their own. This presents problems in a rural area. To some extent, we have been using nursing homes as a substitute for half-way houses; patients who are able contribute partially to their own support by working in the home. In a few instances, patients improved enough to obtain outside employment and leave the shelter of the nursing home. Now, with the help of a local nursing home operator, we are planning to develop a half-way house in a larger community 30 miles away. In this community, the operator hopes to buy a house with room for 10 to 15 patients to live in a boarding-house atmosphere. She plans to hire a couple to supervise the house, and, during visits once or twice a week, our vocational rehabilitation staff will assist with supervision. If this plan is successful, we can carry it out in other towns within 50 miles of the hospital.

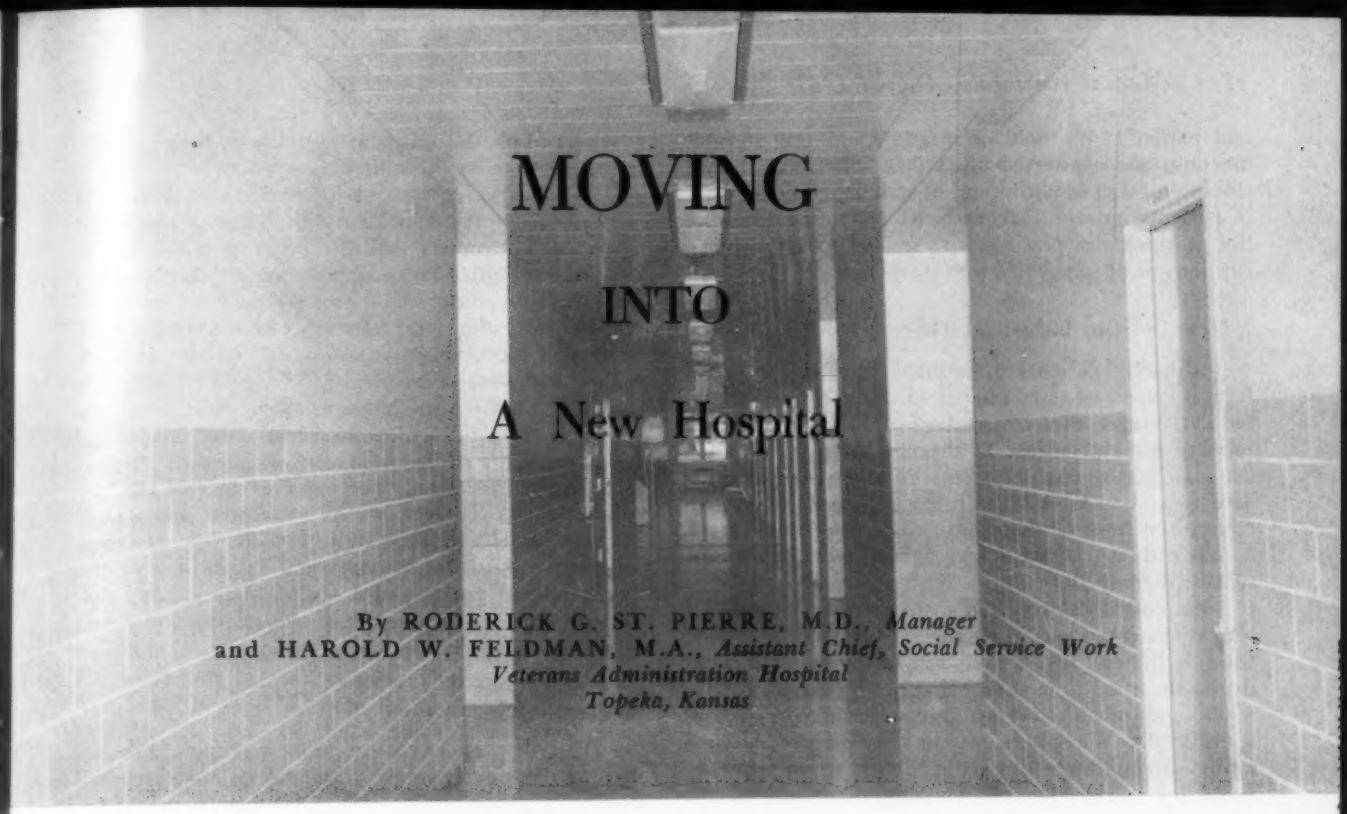
We believe that none of our programs duplicate the functions of the state OVR program. A number of our patients continue to need more supervision than the state program can supply; referral to the OVR is too big a step for them. Also, patients who are not ready for the specialized services of OVR may still benefit from the hospital rehabilitation program and eventually reach the OVR referral stage. •

Homemaker Service Demonstration

A TWO-YEAR DEMONSTRATION project to provide homemaker services for recipients of Old Age Assistance is now nearing completion in North Carolina. The project is under the direction of the State Department of Public Welfare, and is supported by a private-foundation grant of $20,000 supplemented with federal matching funds on a dollar-for-dollar basis. The objective of the demonstration has been to determine the extent to which homemaker service provided through a public welfare resource could reduce the needless institutionalization of older persons, with a consequent saving in costs.

Homemakers, after an initial training period, are employed and paid by the local welfare department. They are selected by the county superintendent of public welfare, employed under the state merit system regulations, and paid a monthly salary within the merit system range. The majority are between 40 and 45 years of age.

In the opinion of the sponsors, results of the demonstration have exceeded expectations. The service has reduced unnecessary admission of older persons to institutions, led to better use of limited financial resources, and decreased the need for more costly types of care. These people merely required a small amount of help with the more demanding physical activities of daily living. The program has been well received by the medical profession in the area.



MOVING INTO A New Hospital

By RODERICK G. ST. PIERRE, M.D., *Manager*
and HAROLD W. FELDMAN, M.A., *Assistant Chief, Social Service Work*
Veterans Administration Hospital
Topeka, Kansas

On August 27, 1958, between 7 a.m. and 1 p.m., we transferred 900 patients from the old 1,200-bed Winter Hospital to the new 1,000-bed VA Hospital in Topeka, Kansas. Then, in the new plant, we served lunches for 1,050 people. Only those who have been involved in such a major undertaking can appreciate the months of planning, coordinating, and preparation which lie behind these laconic statements!

Not surprisingly, the change had a major psychological impact on our patients, and it is this aspect of the move that we will discuss here. Those interested in the logistics of the transfer may obtain a full report upon request to the manager, including details of the planning and equipment, and a chronology of the physical operation.

In September, Dr. R. E. Reinert, then acting director of professional services, began a study to gain some insight into and appreciation of the feelings and fantasies expressed by patients before the move took place and of the modifications that followed it. Residents and staff psychiatrists completed questionnaires. The following extracts indicate some of the patients' pre-move attitudes:

Dr. A reported that several groups of female patients on the open section of the acute intensive treatment ward were concerned about rumors that patients would be locked up after 4:30 p.m.; that male patients would not be allowed to associate with female patients; and that doors would be locked. Doctors, appearing at patient-council meetings, were able to dispel or reduce such fantasies by clarifying the misconceptions that patients held about the hospital.

Dr. B found that between 50 and 75 female patients feared that there would not be room for them in the new hospital. They commented on its "prison-like" appearance and revealed feelings of low self-esteem, apparently viewing the hospital as an untrustworthy luxury. They, too, circulated the rumor that the female patients would never be allowed to speak to male patients after the move.

Dr. C found that nine out of 27 chronic male patients expressed fear or reluctance about the move, frequently elaborating on the minor advantages of the old hospital, such as the porches, the conveniences of the canteen, and so on.

Dr. D reported that seven out of 26 male patients also expressed fear or reluctance about the move. After it took place, however, they seemed to adjust rather more quickly than some of the personnel!

Dr. E's patients expressed concern that they would not get the same standard of psychiatric care; the doctors would give patients less personal attention, they thought, because the new hospital facilities made psychiatric care unnecessary. This concern seemed to be related to fear of rejection and becoming lost and confused in the new surroundings.

Dr. F said that eight out of 19 patients on a closed male ward were openly reluctant or fearful of the move and expressed similar feelings immediately after it occurred. Many changes of nursing personnel and separation of patients from fellow patients prolonged the period of reorganization.

We tried to make the transition from the old to the new hospital as painless as possible for both staff

and patients. We held orientation and preparation meetings and conducted tours. We tried to maintain stability of staff organization, of staff assignments, and of patients' groups. We restored recreational activities as quickly as possible, and strived to keep interruptions of all programs to a minimum.

A New Twist in Industrial Therapy

Allowing patients in industrial therapy to perform a variety of tasks related to the move proved to be a strikingly effective method of helping them to prepare for and adjust to the new hospital. About 200 male and 30 female patients were assigned to such activities. A total of 37 adjusted well to daily assignments, and most of these have since been discharged or released on trial visits. A larger number could not sustain their initial efforts.

Employees noticed that many patients who were actively involved with the move seemed to take a new lease on life and regain their zest for living. This evidently stemmed from their being productive in worthwhile and meaningful assignments, and they were stimulated by the opportunity to leave their old, accustomed surroundings for part of the day to work in the new hospital. Sharing coffee breaks, working in smaller groups, and receiving recognition and encouragement from the staff obviously were important factors in the success of the patients' adjustment to this new form of industrial therapy. The tasks themselves increased the patients' self-dignity and self-esteem. Apparently, it was more gratifying for them to work with other patients and employees in moving supplies and equipment than to do the routine work of maintaining the hospital grounds under supervision.

One of the chief benefits of this participation resulted when the patients working on the move spread the word among others, giving them glowing accounts of the new hospital's bright facilities and accommodations. This did much to dispel fears based on distorted notions or groundless rumors.

"What do you mean, just a few alterations and you have room for three more beds . . . ?"

The experience of using patients in industrial therapy assignments incidental to the move persuaded many staff members that the program could be extended into other areas, notably supply, engineering, and dietetics. Since the move, the program has been expanded to the point where we now have two full-time staff members supervising 297 patients in individual industrial assignments, as compared with 180 patients working in January 1958. Additional patients work in two group industrial assignments, and the hospital goal is to promote industrial therapy placements in virtually every department of the hospital. More than ever, we are convinced that a well-planned and diversified industrial therapy program, directed toward the interests and capabilities of the patients, and supervised by understanding, psychologically oriented personnel is a rewarding and meaningful form of therapy.

Surprising By-product

One by-product of this move was somewhat surprising. We had assumed that the less we disrupted the program and personnel, the better it would be. But, in fact, this major change seemed to provide the very climate needed to overcome long-standing inertia and resistance to changes in methods, policies, and patterns of operation that were in urgent need of modification. A sense of urgency was conveyed when the manager and the director of professional services insisted upon the need to attend to certain long-standing problems along with planning the move.

A large-scale move of this kind is stressful both for patients and staff. Our experiences may serve others as a foundation for sound planning and smooth operations. Our most useful devices were:

1) A timetable, carefully prepared with the help of chiefs of service, listing target dates for various stages of the operation. This promoted smooth operation, and insured optimum use of personnel and hauling equipment.

2) Gradual orientation of patients and personnel to the new physical facilities. This procedure helped planning and reduced anxiety caused by distortion of facts.

3) Carefully planned use of selected patients in productive work assignments within their capabilities. We discovered that this type of program should be fostered not only in special situations but also in daily hospital operations as an integral part of the total treatment program.

4) Maximum participation of patients and staff. This reduced apprehension and increased healthy anticipation.

Most important of all is the quality and extent of communication among all staff personnel. •

IV. Emergency Services, Including Mental Health Clinics, Psychiatric Units In General Hospitals, and Private Psychiatrists, Can Contribute to Public Understanding and Secondary Prevention

Action For Community Involvement

By JOHN P. LAMBERT, M.D.
Medical Director
Four Winds
Katonah, New York

WE ARE LIVING IN A TIME of challenge to our profession, confronted with a mental illness problem of the first magnitude and a woeful shortage of programs and personnel to solve it. Our primary concern is for the mentally troubled human being. For him, the mental hospital should be a way station back to the community, not a terminus he has reached after other measures have proved to be inadequate. Yet we know that many individuals of all ages are necessarily denied direct psychiatric help. Are we tending to stress and bemoan the weakness of the resources at our command, or are we bending every effort to seek out, strengthen, and integrate those we do have?

Do we, for example, see the home as a stabilizing force for the promotion of mental health, as the first line of defense for the potentially ill patient or for the one who has just left the mental hospital? Are we utilizing all of the cultural, educational, spiritual, recreational, and economic forces of local communities and of the nation in our cause? Have we enough reliance on and cooperation with the many other groups and individuals who may have strength and hope to share with the mentally ill and may be capable of offering them the kind of warm fellowship and support, free of stigma and judgment, that can be so vital to the maintenance or restoration of mental health? Have we enough faith in such specialized lay groups as Alcoholics Anonymous, which is self-defined as "a fellowship of men and women who share their experience, strength, and hope with each other" in order to "stay sober and help other alcoholics achieve sobriety"?

These are some of the questions posed by the Final Report of the Joint Commission on Mental Illness and Health and some of the questions we must ask one another during the 13th Mental Hospital Institute. In reviewing the findings and recommendations of the commission, we are certain to be stimulated to question them further and equally certain to arrive at some workable solutions.

Our Schools as Resources

"Persons who are emotionally disturbed—that is to say, under psychological stress that they cannot tolerate—should have skilled attention and helpful counseling available to them in their community if the development of more serious mental breakdowns is to be prevented," warns *Action for Mental Health*, the Final Report of the Joint Commission on Mental Illness and Health.

In the absence of fully trained psychiatric personnel "such counseling should be done by persons with some psychological orientation and mental health training and access to expert consultation as needed."

Although Allinsmith and Goethals[1] see the family as the best vehicle for the promotion of mental health, they point out that "the family is a rather isolated unit of modern society" and that it is not "readily accessible to outside help, except as it seeks it."

They consider that, for most children, the school is "a ready-made setting with the potentiality for directing, reinforcing, or correcting mental health." They recommend that teachers be better trained in academic subjects and instructional techniques as well as in "determining differences in pupil aptitudes, motivations, and personalities." Teachers also should be more aware of their own values and biases that may affect their relationships with their pupils.

The authors believe that the school system rather than the already "overburdened" teacher should be responsible for seeking treatment on a child's behalf, once his difficulties have been recognized; they recommend that every school "employ or have access to well-trained school psychologists." Teachers should under no circumstances assume the role of psycho-

This is the fourth of a series of articles on Action for Mental Health, the final report of the Joint Commission on Mental Illness and Health. The series is sponsored by the Program Committee for the 13th Mental Hospital Institute, and is intended as orientation material for Institute discussions.

[1] *Allinsmith, Wesley, and Goethals, George W.: The Role of Schools in Mental Health, Joint Commission Monograph Series, No. 7, Basic Books, Inc. (In preparation)*

therapists, but they are in an ideal position "to detect mental disorders when they have been alerted to the symptoms" and to refer the child to the proper professional resources. They also can play an important part in reinforcing professional treatment and in cooperating with parents. Both teachers and parents must be educated to realize that they can function most effectively as a team if the parent assumes full parental responsibility instead of expecting the teacher to carry the load. Teachers themselves must sometimes guard against the temptation to become parent-substitutes.

Allinsmith and Goethals find that many psychologists working in schools today have had little training beyond a bachelor's degree. They contend that psychologists suited for work in schools should be "explicitly trained at the doctoral level in school psychology and guidance. Such psychologists will need greatly elaborated staffs of counselors with at least one or two years of graduate training if the goal is to be met in the elementary and secondary schools of the nation."

School administrators and school boards must achieve a better understanding of primary and secondary prevention of mental illness before the goal of adequate, integrated mental health services for all schools can be met.

Our Churches as Resources

McCann[2] finds that "the church offers as great a potential as a mental health resource for adults as does the school for children," and that more mentally troubled Americans turn to their clergyman for help than to their family physicians. The church's major contribution at the present time is, of course, pastoral counseling, but it has developed a new resource within the past decade. This usually takes the form of a church counseling center, under Protestant sponsorship in most cases and located in larger cities.

"While there is some concern that this medium may expose the community to inadequately trained personnel," says McCann, "it seems to be fostering greater cooperation between religion and mental health resources and is valuable as a screening agency and as a center for advanced clinical training of the clergy in a parish setting."

Clergymen, as mental hospital chaplains, minister directly to the mentally ill, and, in this area as in the community at large, McCann finds that "the effectiveness of clergymen as psychological counselors appears to depend much more on their capacity for understanding human nature and on the warmth of their personalities than it does on their professional training or orientation" or "the religious faith or social and economic status" of the person seeking help. Is it not possible that, in all phases of work with the mentally ill, warmth of personality and human compassion may be more vital ingredients than we realize?

McCann suggests that the clergy should have better preparation in the social sciences in order to concentrate their efforts more effectively on prevention of mental illness, assistance to families of the mentally ill, and intervention in times of crisis. They can give these aids partly by means of ritual and partly by simple, direct support.

Additional Nonmedical Resources

In *Community Resources in Mental Health,* Robinson, DeMarche, and Wagle[3] explore a number of nonmedical resources. Chief among them are:

- *The public health nurse,* who "could deal more effectively with mental health problems if she had more training in this aspect of her duties and especially if she could seek advice of the professional consultants who now are rarely accessible to her."
- *Social security* and other forms of public financial assistance to the elderly, the disabled, and the unemployed.
- *Child welfare programs* such as Aid to Dependent Children, court services, adoption services, day-care services, homemaking services, and recreational agencies like the Boy and Girl Scouts, the YMCA, the YWCA, the 4-H Clubs, and youth centers in urban areas. The Robinson team found that "there are not enough child welfare workers, and those available are usually over-burdened with high case loads." The quantity and quality of adoption services should be increased, and the nation needs more and better parole officers. In the recreational services, as well as in all other areas of child welfare, they found a crying need for more funds and more trained personnel.
- *Family case work agencies,* usually found in large cities, staffed by graduate social workers with access to psychiatric consultation. Since most of these agencies exist where mental health clinics also function, they might well, as the authors suggest, concentrate on providing social rather than medical services, and give more attention to "determining the levels of treatment and kinds of mental and emotional problems that can best be dealt with by different community services."
- *Volunteer college students* in mental hospitals are a new resource. The commission recommends that their work and that of other hospital volunteers should be "encouraged and extended." Students can have a therapeutic effect in large, under-staffed hospitals, develop greater insight into and more tolerant attitudes toward the mentally ill, and perhaps be influenced to enter a career in the mental health field.

Robinson and his associates conclude that in each community, mental health programs must be geared

[2]*McCann, Richard V.: The Churches and Mental Health, Joint Commission Monograph Series, No. 8, Basic Books, Inc. (In preparation)*

[3]*Robinson, Reginald; DeMarche, David F.; and Wagle, Mildred K.: Community Resources in Mental Health, Joint Commission Monograph Series, No. 5, Basic Books, Inc., 1960.*

to local needs, but that "initiative must be taken, most logically by the states, to provide consultation in depth for local planning." They found many mental health programs currently being implemented by teachers, clergymen, probation officers, sheriffs, judges, public welfare workers, scoutmasters, and others. "Whatever their qualifications, they are trying to do something to help individuals with mental problems; they know that if they don't make the attempt, the chances are that no one will. . . . The initiative for the creation and development and coordination of mental health resources in communities rests solidly with mental health leaders. It is up to them to show the way. And in the process of helping to develop these resources, they will have to learn to live with their reliance on many other individuals who, by force of circumstances, are involved in the treatment of mental and emotional disturbances."

On the basis of these findings, the final report recommends: "That nonmedical mental health workers with aptitude, sound training, practical experience, and demonstrable competence should be permitted to do short-term psychotherapy—namely, treating persons by objective, permissive, nondirective techniques of listening to their troubles and helping them resolve these troubles in an individually insightful and socially useful way. Such therapy, combining some elements of psychiatric treatment, client counseling, 'someone to tell one's troubles to,' and love for one's fellow man, can obviously be carried out in a variety of settings by institutions, groups, and individuals, but in all cases should be undertaken under the auspices of recognized mental health agencies."

Aftercare, Intermediate Care, and Rehabilitation

Does the community, as well as the psychiatric facility, have a vital role to play in this phase of the mental health program? The chief role of aftercare, according to Schwartz,[4] is "the prevention of relapse and rehospitalization. Accordingly, these programs aim minimally at maintaining the level of recovery achieved at the point of discharge, and hopefully at fostering further improvement."

Many aftercare services are so new that, as yet, we know little about their characteristics. The most important types of facilities are described briefly below:

- *Aftercare clinics:* Some are located at mental or general hospitals and are run by the hospital staff for its own ex-patients; some are traveling clinics serving ex-patients who live at a distance, and some are administratively independent of any hospital.
- *Day hospitals:* These may give full hospital treatment to persons who return home at night, or may serve as daytime centers for "prevocational, recreational, and social activities designed to help patients live more adequately in the community." The three concepts behind day hospitals are: (a) "Patients do not need to stay in bed"; (b) "They do not need to stay in the hospital until they are well and should not remain when they are able to leave"; and (c) "Treatment should not be limited to the patient but should include his family and home and his social setting."
- *Night hospitals:* These make treatment available without interfering with the patient's work or his other daytime responsibilities. Night hospitals are economical and valuable; they can use day hospital facilities and provide overnight service for psychiatric emergency cases.
- *Public health nursing services:* These have only recently been broadened to include care for the mentally ill. Schwartz's group finds that the special contribution of the public health nurse is to render supportive help to families of the mentally ill, to administer and supervise an ex-patient's tranquilizing drugs, and to give home care to ex-patients who are elderly or in need of continued medical attention.
- *Foster family care, the oldest form of aftercare in America:* This "is a way of rehabilitating former patients and returning to normal living many who would otherwise remain hospitalized. It relieves overcrowding of mental hospitals, is less expensive than hospitalization, and often convinces patients' families they should take them back."
- *Halfway houses, or residences where ex-patients may live in a "protected setting":* These may be cooperative urban residences limited to ex-patients of one sex "with good enough remission to get along with minimum supervision, and potentially or immediately employable"; ranch or farm houses that are work-oriented and accept patients of both sexes as well as persons who have never been in a mental hospital; and treatment-oriented houses where "the residents are still patients and are not required to assume any large degree of personal or domestic responsibility or to participate in community life."

In evaluating halfway houses as a mental health resource, we must ask ourselves: do such segregated residences simply perpetuate the separation of the ex-patient from the community more than does foster family care? Or do they offer more freedom and privacy than foster family care and provide the ex-patient with a needed experience in independence?

- *Convalescent nurisng homes:* These only recently have been considered "a better solution than the mental hospital for the care and treatment of the aged and aging mentally ill." However, few such homes are willing to accept elderly disturbed patients, and those that do "rarely see rehabilitation or the prevention of further deterioration as their major goal."
- *Work services, such as state vocational rehabilitation agencies, rehabilitation centers, sheltered work-*

[4] *Schwartz, Morris S.; Schwartz, Charlotte Green; Field, Mark G.; Mishler, Elliot G.; Olshansky, Simon S.; Pitts, Jesse R.; Rapoport, Rhona; Vaughan, Warren T., Jr.: New Perspectives on Mental Patient Care, Joint Commission Monograph Series, No. 9, Basic Books, Inc. (In preparation)*

shops, and employment services: These facilities generally are more oriented toward assisting the physically disabled than the mentally ill. Many are reluctant to accept ex-mental patients because they are unable to provide adequately for them. The Schwartz group states that ex-mental patients' "capacities for work need to be carefully evaluated, and other services, such as vocational counseling, and psychiatric and medical treatment, may be required before work progress can be made."

• *Ex-mental patients' clubs:* These primarily may be social clubs, aid societies, or therapy groups. They generally tend to be "unstable and short-lived," especially when they attempt to function without professional guidance or consultation.

"Aftercare services for the mentally ill are in a primitive stage of development almost everywhere," the Schwartz group concludes. "Where they do exist, services and agencies caring for the former patient tend to split off from mental-patient services as a whole, and, further, to approach the patient's problems piecemeal. Rehabilitation agencies should work closely with treatment agencies, and preferably have representatives in institutional settings. . . . We may generally state that we favor the great variety of efforts being made to furnish rehabilitation services before, during, or after hospitalization, so long as they are soundly conceived, well-staffed, and operated as part of an integrated system of mental patient service. . . . The day hospital should play an increasingly important role in the care of both acute and chronic mental patients."

Public Information

A broad program of public education is essential to implement and improve upon the various services described, to bolster their weaknesses and publicize their strengths, and to gain the public's moral and financial support. In its recommendations on this aspect of the mental health program, the commission's final report specifies that we "should avoid the risk of false promise in 'public education for better mental health' and focus on the more modest goal of disseminating such information about mental illness as the public needs and wants in order to recognize psychological forms of sickness and to arrive at an informed opinion in its responsibility toward the mentally ill."

Have we perhaps erred in our overinsistence that the public recognize the mentally ill as sick and regard them no differently than the physically ill? Has the time now come when we should instead stress the ways in which mental and physical illnesses *differ*?

The commission recommends that the public information program should have four general objectives:

• "To overcome the general difficulty in thinking about recognizing mental illness as such—that is, a disorder with psychological as well as physiological, emotional as well as organic, social as well as individual causes and effects."

• "To overcome society's many-sided pattern of rejecting the mentally ill, by making it clear that the major mentally ill are singularly lacking in appeal, why this is so, and the need consciously to solve the rejection problem."

• "To make clear what mental illness is like as it occurs in various forms and is seen in daily life and what the average person's reactions to it are like, as well as to elucidate means of coping with it in casual or close contact. . . ."

• "To overcome the pervasive defeatism that stands in the way of effective treatment. While no attempt should be made to gloss over gaps in knowledge of diagnosis and treatment, the fallacies of 'total insanity,' 'hopelessness,' and 'incurability' should be attacked, and the prospects of recovery or improvement through modern concepts of treatment and rehabilitation emphasized. One aspect of the problem is that hospitalization taking the form of ostracism, incarceration, or punishment increases rather than decreases disability."

The commission further recommends that "the American Psychiatric Association make special efforts to explore, understand, and transmit to its members an accurate perception of the public's image of the psychiatrist." It follows that each one of us has a personal responsibility to be increasingly aware that we are representatives of our profession in all of our contacts with patients, families of patients, and nonmedical personnel working side-by-side with us in the field of mental health.

Since, as the commission points out, laymen tend to resent the physician's assumption of authority in the laymen's own field of expertness, "the primary responsibility for preparation of mental health information for dissemination to laymen should rest with 'laymen' who are experts in education and mass communications and who will work in consultation with mental health experts."

The commission concludes that, as a matter of basic policy, "the mental health professions can now assume that the public knows the magnitude if not the nature of the mental illness problem and psychiatry's primary responsibility for care of mental patients. Henceforth, the psychiatrist and his teammates should seek ways of sharing this responsibility with others and correcting deficiencies and inadequacies without feeling the need to be overbearing, defensive, seclusive, or evasive. A first principle of honest public relations bears repeating: To win public confidence, first confide in the public." •

NOTICE

In the July issue of MENTAL HOSPITALS, *the mattress shown in the Karoll's advertisement at right appeared in the wrong color. This advertisement shows the correct shade of turquoise for the mattress. Our apologies to Karoll's for the error in printing.*

Dr. Whoozis Wouldn't Understand

By DR. WHATSISNAME

DR. WHATSISNAME has a brother-in-law—also an M.D. Dr. Whoozis is a nose and throat surgeon in the big city. His Cadillac and his wife's Chrysler and his little motor boat have been financed by a mound of extracted tonsils. Dr. Whoozis is a success; he will not make house calls. He has always considered his wife's brother something of an odd-ball. After all, Dr. Whatsisname chose to associate with the mentally sick all day. And what is worse, he accepts a salary which, for a doctor, is practically un-American.

Last month Dr. Whoozis spent a whole week visiting the mental hospital. He met the staff, sampled the coffee in the Hospitality Shop (he didn't like it), sat in on a staff conference, and prowled around the corridors. He hasn't changed his mind.

He thinks, indeed, that now he knows why doctors choose to work in public mental hospitals. They lack initiative, he says, so they thrive in a community where decisions are made for them. They are lazy, so they prefer a career where the hours are short and fixed and where too much zeal or energy leads to a reprimand. They shirk responsibility, so they hunt for a spot where every decision can be buck-passed to a superior. They lack the courage to face competition. They lack the professional skill to go into a specialty that deals daily with life and death.

"Of course, it's all right for you, brother-in-law," Dr. Whoozis says generously, "because you get this rent-free mansion with a staff of patients to do the housework." (The staff consists of an inside man who is a deteriorated epileptic, an outside man who is an alcoholic, and a cleaning woman in an involutional depression.) "All right for you, brother-in-law, with all these amenities . . . but as for your staff, well, there must be something wrong with them to work here. . . ."

And in a way, Dr. Whoozis is right. He speaks in the name of the average physician who, by definition, is a private practitioner and, therefore, is bossed by no man (or by a thousand).

How can a staff doctor in a public hospital defend himself against this impeachment? He can say, of course, that he works in a hospital because he is dedicated to the cause of human welfare, patient happiness, or mental hygiene. No one, however, will believe so pious a defense. A more acceptable reason would be simply that he works in a mental hospital because he likes it there. He is endlessly enchanted by the vagaries of humanity. He prefers a climate where he can order a gastrointestinal X-ray without worrying about whether the patient can afford it. He likes the challenge of being able to cope with anything, *but anything*. He knows that his hospital is the place to which the private practitioner sends the cases he can't handle. This pleases him because he is often the friend in need to practitioners in crisis. He likes the comfort of being part of a team, with an interested junior to teach and a seasoned senior to share his problems. He knows that someone must work in our mental hospitals, that therefore he is doing a much-needed job, and that there is satisfaction without sanctimony in doing this job.

He is intellectually stimulated by having a good medical library and a well-supplied pharmacy down the corridor; by having the cases, personnel, and facilities for research; and by being in a "teaching" atmosphere. His sense of professional dignity is heightened by freedom from the financial nexus which can contaminate a doctor-patient relationship, and by the replacement of interprofessional competition with collaboration. And there is richness in having a box seat to see the most vivid enactments of the dramas of the human mind—and occasionally being able to step down and direct them to a happy conclusion.

But there is no use in telling all this to Dr. Whoozis. He wouldn't understand.

Work Therapy in the Soviet Union

By GEORGE J. WAYNE, M.D., F.A.C.P.
Director, Edgemont Hospital
Los Angeles, California

DURING MY VISIT to the Soviet Union in 1959, I was particularly interested in the use of work as a therapeutic procedure for psychotic and neurotic patients. I observed the use of work therapy at the famous Bechterev Institute in Leningrad and discussed it with Drs. Timapheyev and Rubinova in relation to the full program of psychotherapy. Comparable programs exist elsewhere in the Soviet Union, but Bechterev is one of the main centers. It provides therapy for inpatients and outpatients, and its staff directs work therapy in outpatient dispensaries and other hospitals throughout Leningrad.

Physically, Bechterev Institute is a far-from-impressive group of substandard and outmoded buildings. A group of factory-like shops, where patients spend part of each day at productive work, occupies a sizable area of the hospital.

Work therapy differs markedly from conventional types of occupational therapy. It is not a "make work" program; there is no aimless tinkering—no feeble attempts at ceramics or fingerpainting, no indulgent or condescending attitude toward what is being done or toward the end-product. The patients are seriously occupied at what is considered in the Soviet Union to be the most meaningful and significant of human activities—production of materials for practical use. The shops are admirably equipped by any professional standards. In them, the patients manufacture fountain pens, buttons, hammocks, gymnasium equipment, fabrics, and furniture.

Quality Workshop Merchandise

The shops are supervised by technical experts who set and maintain high standards of proficiency. The products—good quality merchandise that competes with commercially produced goods—are sold to the general public through stores. Proceeds from their sales are used to purchase new equipment for Bechterev and to pay for maintenance repair work.

The Bechterev shops look like an authentic factory, albeit a small one. But it is evident that the workers are ill; some of them are alert and zealous in their work, and others are dull and withdrawn, limited to simple and routine assignments. Each patient is encouraged to work at his full capacity, but the atmosphere is kept free from tension and stress, and, in contrast to the rest of the Soviet Union, is essentially non-competitive. Some patients work only one hour a day. Others, particularly those being treated in the outpatient dispensaries, may put in a full workday. The length of the workday and the complexity of the tasks are increased as the patients improve; payment is commensurate with production.

The aim of the program is to get each worker back to his job as soon as possible, with his basic skills unimpaired. This, of course, is highly consistent with the aim of Soviet society. Six months is considered the maximum time for treatment in work therapy, although everybody—the therapists, the patient, and the government which assumes the full cost of patient-care—is gratified if recovery is effected earlier.

Technical experts who supervise the workshops are under the direction of the psychiatric staff. Psychiatrists also make daily rounds of the workshops, where each patient's program includes regular sessions with a psychiatrist, either on a group or individual basis.

A worker is usually encouraged to continue the type of work he was doing before he became ill, so that his recovery is equated with the resumption of his productive function in the social organization. The Bechterev Institute, however, is equally alert to the need for some vocational retraining and provides it.

I was particularly interested in the approach to aptitude testing and assessment for vocational retraining. Soviet psychiatrists place less emphasis on particular capacities than they do on the individual's response to a total situation in which his capacities, interests, and motivation all play a part. We accept this approach in theory, but in actual practice we still attach undue importance to isolated tests of specific aptitudes.

Vocational Redirection

Utilizing this Gestalt approach, the staff at Bechterev often redirect patients vocationally and provide them with the equipment and supervision needed to train them for their new work. This retraining program includes brain-damaged patients, hemiplegics, and others for whom occupational redirection is indicated.

As far as I could tell, the entire work-oriented program of therapy was structured only for production workers. I don't know what happens to a white-collar worker, a creative person, or a physician in the Soviet Union who suffers a mental breakdown.

Many patients at Bechterev receive somatic therapies, such as drugs, electroshock, sleep therapy, and

THIS MONTH'S COVER—
THE ARTIST'S CONCEPTION

"Work Therapy in the Soviet Union," the article chosen for illustration on this month's cover, is fertile material for the artist. Its theme and tone imply that work therapy in Russian mental hospitals reflects the strongly machine-oriented philosophy of their whole society. Production is the basic goal.

The cover design suggests a machine motif, with the four pictures representing cylinders, or pistons, of an engine. The four individuals, including the psychiatrist in the first picture, are "compressed" into identical shapes, or cells. They are so positioned that the eyes of each person are on approximately the same level, forming an axis or crankshaft. The solid brown background color connotes something of the vastness and the mystery of the USSR.

GEORGE DOTY

physiotherapy. Physicians use more or less the same drugs that we do, although without the thrust of a highly competitive pharmaceutical industry they cannot obtain the great proliferation of each type. Drug therapy is, of course, most acceptable within the Pavlovian organic orientation.

The psychotherapy which underlies and supports the work program also reflects Pavlovian neurophysiological theory, and is, by Western standards, limited in depth. The Pavlovian approach is concerned primarily with the functioning of the cortex as the control center and the conscious, thinking element of the brain; facts are stored, and ideas are developed in the cortex. Function is explained by stimulation-inhibition systems, and malfunction by excessive stimulations of a portion of the cortex. Treatment consists of creating other points of stimulation, which will inhibit the affected or malfunctioning area.

Behavior is described in terms of unconditioned reflexes, which are innate; conditioned reflexes, which are learned patterns acquired during the developmental phases of the individual; and a "second layer" of conditioned reflexes which are derived from and dependent upon those originally learned. This concept binds all activity into a complex, interconnected pattern which is essentially neurophysiological. Psychotherapy, within this framework, is primarily activity therapy, of which work therapy is a most important example.

The Soviet Psychiatrist's Approach

The psychiatrist, under this orientation, deals with the conscious, rational elements of his patient's life situation. At Bechterev he devotes most of his interview time with the patient to explanation, suggestion, guidance, and advice concerning the patient's work performance and work relationships. The psychiatrist emphasizes the importance of the social organization, and the satisfactions available to the patient when he is able to fulfill his social duty by returning to work.

The Soviet approach to mental illness can be gauged, to some extent, by their ratio of mental hospital beds to the general population – a proportion markedly lower than ours. In New York state, there are 7 beds in public institutions for 1,000 of the population; in California, the ratio is 2.3 per 1,000, but is substantially augmented by beds in private hospitals. The Soviet Union reports less than one mental hospital bed per 1,000 population, and, significantly, contends that it does not need more. Physicians are concerned with treating patients outside the hospital as much as possible. They do not approve of removing the patient from his life work during treatment; since they believe that the social experience is the core of mental health, they aim to keep the patient operating constructively within his community. Clearly, work therapy is a specific affirmation of this premise.

I cannot tell how lasting are the results of this work-oriented program. But what I saw was impressive and seemed to be effective; I felt that the basic rationale was sound. I can evaluate and relate these programs to our own only in tentative terms, but I believe that several of my observations and inferences are pertinent.

Work therapy as practiced in the Soviet Union obviously is linked directly to the basic Marxian concept of the social usefulness of work. In a communist society, work—both philosophically and socioeconomically – is the central core of life. Children are taught to love people, to love work, and to place special value on getting along with people with whom they work. Structured "play" with social goals is started earlier in Soviet nurseries than in our own.

Work in the Soviet Union is obligatory and compulsory, in distinction to the mobility and freedom characteristic in this country. Naturally, this difference drastically modifies the sense of personal fulfillment which the individual can derive from work. On the other hand, the social value attached to work in the Soviet Union and the dedicated attitude of the individual infuses the work-therapy program with a propulsive vitality which, perhaps, could not be matched in this country.

Marxist Appraisal of Freud

"Personal fulfillment" is the key term in differentiating between the goals of psychiatry in this country and in the Soviet Union. Soviet psychiatrists do not try to provide the individual with self-understanding through self-examination. They consider the Freudian approach to be inimical to Marxism, and do not define the individual's developmental processes basically in terms of sexuality.

While Soviet psychiatrists agree with Freudians that sexual phenomena may be significant symptomatically, they do not accept the premise that sexuality is causally important to disturbed behavior. Therefore, they resist concern with the patient's unconscious conflicts – with what we term the psychodynamics of behavior. Soviet psychiatrists think that the type of problems which trouble the average psychiatric patient in this country are essentially decadent, bourgeois problems without counterparts in their own society. They assume that, as their society moves closer to complete realization of Marxian political and economic goals, even the complex and elusive problems of the individual will be substantially solved. They believe that individual fulfillment is not achieved through personal attainment and acquisition, but through contribution to society.

Thus the psychiatrist concerns himself primarily with identifying experiences in the patient's background which are related to socioeconomic wants rather than to emotional deprivations. For instance, they attribute many of the mental illnesses they are now treating to experiences during what, in the Soviet Union, is called the Great Patriotic War—World War II. (Interestingly, mental illness in the Soviet Union increased measurably immediately after the

war; it is reported to be declining at present.)

It is evident that psychiatry plays a relatively modest role in the Soviet Union. Many problems which, in the United States, are the prerogative of psychiatry are dealt with in Russia through other agencies, such as unions and Young Pioneer organizations.

In talking about the characteristic approach to psychiatry in the Soviet Union, I realize that I run the risk of grossly oversimplifying. I do not want to give the impression that their psychotherapy is limited solely to a back-to-work movement. Despite the acceptance of the Pavlovian theory, there are individual psychiatrists who have synthesized a widely different orientation of their own. Evidently some psychiatrists, despite the official rejection of Freud, have been influenced by his concepts; extensive exploration of the patient's highly individual and personal emotional problems is not consistent with the Soviet emphasis, but I understand that there are some psychiatrists who are especially gifted in dealing with such problems and that they do practice dynamically oriented psychotherapy in the area of interpersonal relationships.

Over-all Goals Inapplicable in U. S.

Is the work-therapy program practiced in the Soviet Union applicable to the practice of psychiatry in this country? Work therapy in the U. S. could never perform the all-developing function it seems to fill in the Soviet Union, partly because we do not share its peoples' single-minded devotion to serving society through work. Moreover, the right of the individual to choose the *kind* of work he does, *when* he does it, and *how much* he does is implicit in our social system. However, even in our highly individualized society, people derive their status, their satisfaction, and their sense of identity from the constructive work they do. Work deepens a person's feelings of adequacy and helps him to overcome feelings of helplessness. Learning to work with others molds and strengthens healthy attitudes. Work, in a sense, is a reality-oriented modification of play, and, like play, provides release for physical and psychological tensions. It serves as a culturally acceptable means of sublimating primitive aggressive and erotic needs.

But because of the many levels at which work exerts a reinforcing influence on the individual, we should seriously consider extending and deepening its use as therapy for psychiatric patients. I, personally, am convinced that work, when it is not characterized by an obsessive-compulsive pattern, has special and lasting value for everybody, whether they are healthy or disturbed, products of our Western culture or of another system. Most people derive gratification and a sense of fulfillment from work well done. A close relationship seems to exist between a breakdown in the emotional and mental equilibrium and a breakdown in the capacity to work.

We would do well to emulate the Soviet emphasis on the high quality of the products made by patients. We sometimes do our patients a disservice by our indulgent attitude that anything they make in occupational therapy is all right as long as they're kept busy—an attitude which fortunately is falling into disrepute in our more advanced treatment centers. We should not inject stress and tension into the therapeutic environment, but some patients at least might move toward recovery more briskly if they could have the sense of achievement which comes from turning out a good job. With well-equipped workshops and technical supervision, patients could have the satisfaction of doing a good day's work and knowing how well they measure up to others in achievement.

The integration of psychotherapy with vocational training and rehabilitation could be immeasurably strengthened by such programs, which would help patients to leave a mental hospital in reasonable condition to do productive work. Of course, the patient's capacity to resume such a role is linked to the configuration of problems and conflicts which caused his illness, but since we don't defer discharging a patient until *everything* is solved and recovery is complete, we should at least discharge him in the best possible shape to make his way in the world. This calls for maintaining a patient's basic work-skills, identifying patients for whom a drastic occupational change is advisable, and providing the necessary training for such a change.

Vocational rehabilitation agencies are attempting to do just this, but a good deal more could be done properly and economically during the time when the patient is in the hospital.

I certainly cannot submit a blueprint for work therapy programs in American hospitals. Everybody who has had any experience with mental hospital patients will have many ideas in addition to the random notions mentioned here. More important than a plan of action at this stage, however, is the acceptance—within our repertory of therapeutic procedures—of the importance of work as a link between the patient and his own capacities, the people around him, and the world to which he must return. •

I observed an interesting variation of therapeutic procedures during a visit to Sochi, one of a group of official health resorts and spas. Sochi is famous for the curative powers of its sulfur springs and the Soviet physicians who accompanied me urged me to sample several of the treatments, which are used for neurotic patients as well as for those with physical illness. The psychiatrists insist that sulfur has specific therapeutic value for neurotics. My own impression is that the highly organized, hypnotically suggestive, ritualistic procedures associated wtih the treatment are the main ingredient of the cure. I believe that tens of thousands of occult neurotics are kept in adequate compensation by the rites in these sanitarium cities, although Pavlov would certainly turn in his grave if he heard my formulation! G. J. W.

An Alumni Club Carries on . . . .

Where the Hospital Left Off

By FRANK H. LUTON, M.D.
Clinical Director
Central State Hospital
Nashville, Tennessee

HISTORICALLY, THE LETTER "X" has not always enjoyed a good reputation. Long ago, someone somewhere chose it to symbolize illiteracy, tragedy, and the fearful unknown. The tradition has persisted. But to former patients of Ward H-2, Central State Hospital, Nashville, Tenn., who are members of the "X Club," the much-abused letter represents hope and a new life—the healthy adjustment of 17 ex-mental patients.

In October 1960, women who had been released from the ward met together in the hospital's staff dining room to inaugurate their club and to honor members of the staff who had done so much to help them get well. The ladies brought their husbands with them to the dinner and proudly introduced them to the guests of honor. During after-dinner remarks, Dr. O. S. Hauk, hospital superintendent, stated that the club exemplified a gratifying new trend in mental health that, in the past 25 years, has changed the attitudes of patients and their families toward mental hospitalization.

"This is a unique activity of patients who have been discharged and one that offers much promise," Dr. Hauk told the group. "It will do much to break down the stigma that still exists about the mental hospital; it will take into the community an image of the hospital that is much different than it has been and will offer to other discharged patients an opportunity for service that may very well help to fill the gap that existed in their lives prior to hospitalization." His earnest conclusion was significant—"I urge you to come back often for occasions of this kind. We can learn much from you."

Plans Put Into Action

At first, club members planned to meet only twice a year, but they have progressed so well that, during their second official meeting in May, they decided to meet monthly. They discovered that they had gone far toward achieving their original goals: (1) to act as public relations agents for the hospital; (2) to assist their own members and new dischargees from Ward H-2; (3) to provide social activities for patients who continued to be hospitalized; and (4) to try to help similar clubs to form throughout middle Tennessee to welcome patients back home and give them help when they need it.

Only the last goal has failed to materialize as yet, but the women have not given up the idea of accomplishing it eventually. In other respects, they are meeting the obligations they set for themselves. They have donated shower caps, plastic coat hangers, records, and artificial flower arrangements to their former ward. They have also supplied various incidentals to individual patients who needed them.

The club has shown a movie on the ward, sponsored a Christmas party, furnished three Sunday night suppers, and given a luncheon for a patient-friend who receives little or no subsistence from her family. Its assistance to newly discharged patients varies to meet the needs of the individuals. "If they seem to be

withdrawn," club president Mrs. Mary Lee said, "we visit them and encourage them to get back into the social realm. Some are invited to our homes for dinner or to go to a movie. We offer them understanding hearts and sympathetic ears because we know about the inner conflicts that rage within the troubled mind of one who has experienced emotional sickness. They realize this, too, and talk openly to us about their feelings of fear, uncertainty, and inadequacy. We believe that this unloading of the mind has paramount therapeutic value."

In order to carry out their roles as "public relations agents," club members talk freely to others about their hospitalization and of the good care they received. Whenever they can, they recommend Central State Hospital as a first-rate treatment center.

"Something Worthwhile"

The club members consider their activities as opportunities to "do something worthwhile . . . to produce self-respect and a good feeling toward ourselves." They also see their activities as a form of payment to the hospital for services given at a low cost that they could afford. They regard their club as excellent therapy because it encourages them to make every possible effort to overcome their own problems, to gain strength and courage, and to explore life more thoroughly. Most important is the satisfaction they gain from inspiring those who are still in the hospital to get well—a task for which they are particularly suited because the patients are encouraged to know that their X Club friends were once patients themselves.

"During the five and a half years since I was at Central State Hospital," one club member said, "I have felt the need many times to talk to someone who had been in a mental hospital and understood the long, hard, but challenging road to recovery. The X Club answers my need and also affords the opportunity of extending a helping hand to others who are now sitting where I sat only a few years ago."

Another member expressed her feelings by saying, "It is most heartening to come together as a group, see how many have licked this sickness, and draw courage, hope, and determination to press on to new goals, helping others to achieve the once impossible."

The club has few rules or regulations except for stipulated requirements for membership. Members must be women ex-patients of the hospital; have a good attitude toward their past hospitalization and conquering mental illness; and be recommended by a doctor, hospital social worker, or a member in good standing.

"Our club is small compared to most others." Mrs. Lee said, "but with courage, determination, persistence, and time we will succeed." And that is the kind of spirit that is helping X Club members to give a new, hopeful connotation to the most maligned letter in the alphabet. •

Train Bell Calls Children to School

A 180-POUND BRONZE BELL that once clanged above a New York Central steam locomotive now is mounted in the yard of the Longview School for the mentally ill in Cincinnati, Ohio. The unique school bell was presented by D. M. Bowles (left), associate director of clinical research of the Wm. S. Merrell Co., and accepted by Dr. Charles Feuss (right), director of Longview State Hospital, and Nick Seta (center), principal of the school.

The school is the only one in an American mental institution which is staffed by a public school system. The state furnishes the building and part of the faculty; the Cincinnati School Board provides several teachers, the principal, and educational materials. The school accommodates 61 student-patients who attend classes and play under conditions as close to those of the outside world as possible. Many are able to graduate, and some now are distinguishing themselves in military service and in college.

The bell rests on a low pylon bearing a plaque which says, "I ring in a new hour for education." Mr. Bowles, having heard about the work being done at the school, decided to give the bell for the enjoyment and inspiration of both students and teachers. At Mr. Seta's suggestion, it was placed low enough for the children to touch it. "They'll want to ring it to celebrate when their basketball team wins," he said. "And maybe we'll even develop a tradition of stealing the clapper at New Year's."

Contemporary Comment

Editor's Note: *"In sum, it[modern psychiatry] represents perhaps, a crucial break-through in man's pursuit of self-knowledge and self-realization" concluded Charles L. Rolo, editor of "The Atlantic Supplement on Psychiatry in American Life," which appeared in the July 1961 issue. Selections from several of the articles are presented below, with the permission of the publisher, Mr. Donald B. Snyder. A measure of the public interest in psychiatry is indicated by the fact that this supplement has been one of The Atlantic's most successful in terms of bookstore sales.*

Mr. Rolo has prepared a selected, annotated list of books for deaders interested in further pursuing the topics discussed; our own readers may find this list of interest not only for their own use, but for public education purposes. It may be obtained without cost by writing to Mr. Rolo of The Atlantic Monthly, 8 Arlington Street, Boston 16, Mass.

From: The Freudian Revolution

"The most revolutionary changes are changes in man's basic beliefs about himself. Three such revolutions have occurred in Western thought in the past five hundred years—the Copernican, the Darwinian, and the Freudian—and they have successively dealt shattering blows to man's pride. Copernicus dethroned man from the center of the universe. Darwin challenged his sense of divinity by tracing his descent to the animal kingdom. And Sigmund Freud, the first cartographer of the unconscious, punctured his conviction that the conscious mind was master of man's fate."

CHARLES J. ROLO

"The voice of the intellect is a soft one, but it does not rest until it has gained a hearing. . . . This is one of the few points on which one may be optimistic about the future of mankind."
SIGMUND FREUD

From: The Language of Pundits

"It is curious that Freud, the founder of psychoanalysis, remains the only first-class writer identified with the psychoanalytic movement. It was, of course, Freud's remarkable literary abilities that gave currency to his once difficult and even bestial ideas; it was the insight he showed into concrete human problems, the discoveries whose force is revealed to us in a language supple, dramatic, and charged with the excitement of Freud's mission as a conquistador into realms hitherto closed to scientific inquiry, that excited and persuaded so many readers of his books. . . .

"The vital difference between a writer and someone who merely is published is that the writer seems always to be saying to himself, as Stendhal actually did, 'If I am not clear, the world around me collapses.' In a very real sense, the writer writes in order to teach himself, to understand himself, to satisfy himself; the publishing of his ideas, though it brings gratifications, is a curious anticlimax."

ALFRED KAZIN

From: A Young Psychiatrist Looks at his Profession

"When the heart dies, we slip into wordy and doctrinaire caricatures of life. Our journals, our habits of talk become cluttered with jargon or the trivial. There are negative cathects, libido quanta, 'pre-symbiotic, normal-autistic phases of mother-infant unity,' and 'a hierarchically stratified, firmly cathected organization of self-representations.' Such dross is excused as a short cut to understanding a complicated message by those versed in the trade; its practitioners call on the authority of symbolic communication in the sciences. But the real test is whether we best understand by this strange proliferation of language the worries, fears, or loves in individual people. As the words grow longer and the concepts more intricate and tedious, human sorrows and temptations disappear, loves move away, envies and jealousies, revenge and terror dissolve. Gone are strong, sensible words with good meaning and the flavor of the real. Freud called Dostoevsky the greatest psychologist of all time, and long ago Euripedes described in *Medea* the hurt of the mentally ill. Perhaps we cannot expect to describe our patients with the touching accuracy and poetry used for Lady Macbeth or Hamlet or King Lear, but surely there are sparks to be kindled, cries to be heard, from people who are individuals."

ROBERT COLES, M.D.

From: Mind and Body

"In many medical communities, young physicians are taught to spend more time collecting data from the laboratory than quietly listening to the patient tell his story in his own words. There has been a tendency to leave this to the psychiatrist. This is an unfortunate result of specialization, because many patients who seem to have straightforward medical or

surgical problems are not given a chance to talk. Psychiatrists have learned to listen. Leaders in the teaching of psychosomatic medicine, such as Franz Alexander, Carl Binger, and Felix Deutsch, have done much to keep the human side of medicine alive. But the emphasis has been to teach this art as part of psychiatry. It should be a cornerstone of medicine."

STANLEY COBB, M.D.

From: Illness and Artistic Creativity

"The cases of Van Gogh and Munch, as well as those of their respective literary contemporaries, Nietzsche and Strindberg, prove beyond doubt that illness as such does not necessarily produce creativity, but often destroys the creative process. Moreover, the various forms of mental disturbance have very different effects upon different artists. Illness can give man a detachment and a courage which the average person does not command. Many artists have broken through the narrow bars of conventionality because of illness and have reached new frontiers which could never have been attained without it. An advancing illness often intensifies anxiety and dread, with a resultant increase in creative output. In Van Gogh, the intensification of perceptual experience gave his vision a depth and color of unheard-of power. In Munch, on the other hand, illness caused suspicious withdrawal from friends, with a progressive narrowing of his experience. . . .

"Modern psychiatry recognizes the cognitive conscious and creative forces in man as that human attribute which enables him to transcend his emotional impressions and to be the creator of an inner world. Psychiatry can help reinforce and integrate the creative abilities and eliminate those fixations which inhibit the free shift between primitive and mature integrative functions. The painter needs identification in empathy and intuition, but at the same time needs the ability to withdraw and fall back on his own self-differentiation. In the neurotic we often find the anxious defense of one aspect of being. Some people never achieve a strong personality structure because the ego boundaries are too fluctuant. In others, the structure is rigid and compulsively petrified, and these people are never able to reorganize themselves and start anew with unprejudiced attitudes."

CLEMENS E. BENDA, M.D.

From: The Rejection of the Insane

"It is true, of course, that these institutions [public hospitals] never have been quite the end of the road that has become fixed in the public's mind. Actually, the number of patients now discharged annually from mental hospitals exceeds the annual number of first admissions. Including in the total figure the accumulated load of old patients who remain stubbornly psychotic, the average state hospital discharges 30 per cent of its patients each year. The worst mental hospitals return to the community 40 to 50 per cent of the patients they treat for schizophrenia, the most serious of major mental illnesses; the best hospitals discharge 75 to 85 per cent. . . .

"The mental health movement is engaged in an uphill pull against intellectual resistance to psychological insight. The nature of the psychotic's trouble impels him to reject social order, and, heeding the ancient law of retaliation, we repay him in kind.

"There is some evidence that the process has begun to reverse itself among younger, better educated people, since we have had a two-generation exposure to psychological and psychoanalytic information. Therapeutic techniques have evolved that break the circle of rejection and defeat it. Evaluations of the psychosocial approaches, proving old truths scientifically, show that some psychiatrists get amazingly good results from psychotherapy with schizophrenics. They also show that other persons, working individually or in groups in hospitals and clinics—social workers, psychologists, nurses, occupational therapists, attendants, enlightened volunteers—can do as much for the psychotic in their way as the psychiatrist can in his (it may be in the same way). In all cases, some kind of as yet ill-defined personal relationship develops between the therapist and patient. In most cases, the secret of reducing the fears, frustrations, and fatigues that beset those who try to work with psychotics is close moral support, given regularly or as needed by the therapist's superiors or peers."

GREER WILLIAMS

From: The New Drugs

"It would be less than objective to omit mention of the limitations of drug therapy, alone or in combination with psychotherapy. Chief among these is its inapplicability to most patients with neurotic disorders. . . .

"But, withal, drug therapy has provided the first new tool of major significance for the treatment and understanding of mental illness in several decades. I would find it difficult to overestimate its role in psychiatric and psychoanalytic practice and theory in the years to come."

MORTIMER OSTOW, M.D.

From: The Century of the Child

"A good example of the high cost of failure in this sphere [child psychiatry] is the problem of juvenile delinquency, which underlines the urgency of applying on a larger scale our existing knowledge about the causes of antisocial behavior. We do not, to be sure, know all of the factors involved in such behavior. But it is well established that its main sources are a disrupted home and a bad environment, which combine to prevent normal integration. If we were to tackle individual and social pathology early enough, the incidence of juvenile delinquency could be substantially decreased. Unfortunately, the emergency programs that are currently being applied are not infrequently confused or inappropriate."

PETER B. NEUBAUER, M.D.

The new Friendship Garden, built for regressed seniles at Logansport State Hospital, is enjoyed by patients, staff, and relatives.

The Friendship Garden

By ERNEST J. FOGEL, M.D., *Superintendent*
Logansport State Hospital
Logansport, Indiana

FEW OF US FAIL TO PROFIT from spending leisurely hours in the out-of-doors. Like beautiful music, the sight of sky, trees, grass, and flowers soothes us inexplicably and helps us to return, refreshed, to our individual routines. At Logansport State Hospital, this is borne out by evidence of the therapeutic benefits our regressed senile patients derive from a garden we designed especially for them.

Since June 1960, 200 of these patients have had the regular pleasure of leaving their wards in good weather to enjoy the attractive lawn furniture, flowers, shrubbery, fish pond, and fountain in the garden. Friendship Garden, as it is called, is more than a bit of improved landscape; it represents our attempt to penetrate the isolation of senile psychotics, broaden their mental horizons, and counteract many of their reactions that defy usual forms of therapy.

In a hospital setting, the regressed senile is a serious problem. His regression is often speeded up by cerebral trauma or a series of physical and psychological disturbances. His history usually discloses many years of alternating lucidity with fixed and rigid attitudes gradually leading to varying degrees of established disorientation. As psychosis develops, the senile tends to isolate himself—a state in which communication is lost and only fantasy can thrive. At best, he passively accepts participation in activities, many of which only increase his reaction formations and heighten his anxiety and restlessness.

The Logansport staff, understanding these problems, explored possibilities for an over-all program that would be acceptable to most of the seriously regressed patients, both male and female. We knew that the program would have to be varied but sedentary, and conducted in a quiet, relaxed atmosphere. As a result, we created Friendship Garden. Our plans for this spectacular formal garden required the experienced counsel of a landscape architect. We obtained one, and by using patients to assist our regular maintenance force with the labor, we completed the garden at a total cost of $3,000.

We designed the garden so that the brick pavilion, which extends over most of the area, provides many shaded spots for group relaxation as well as for individual privacy. It lends itself to mixed social recreation, such as meals and snacks, singing, croquet, and other activities which are appropriate for aged patients. Some patients merely sit quietly and enjoy the sights and sounds around them; others walk about, feed the fish and birds, or visit with their friends and families.

Volunteer Patient-Escorts

Volunteer patients give more than 300 hours of their time each month to escort the aged to and from the garden and supply them with necessary individual services. The volunteers walk with the patients, direct their attention to things that will interest them, and converse with them. The director of the volunteer patients' program, the director of recreation and his staff, and the medical and supervising nursing staffs also visit the garden frequently.

Before we initiated the garden project, our psychology department planned a base line study of a representative group of patients who would use the garden. This was followed up monthly and the study was repeated in midwinter to evaluate evidence of

resocialization on the part of the patients. The psychology department used an objective behavioral adjustment scale, and selected four aides to participate in the rating. It selected 88 of the most ambulatory patients for the study, but did not include a control group. Of these patients, 24 died between October and March, 10 became bedfast, and six were transferred before the midwinter follow-up was completed.

The study, during a four-month period, indicated increased motility, particularly among the male patients who used the garden; for the group as a whole, however, it showed no appreciable changes in cooperation or communication. Personnel, who observed the patients in the garden during the entire year, gave more heartening reports of dramatic changes when these previously hopeless people were exposed to the garden's stimulating milieu. Recreation therapists were impressed by the number who showed interest in the new surroundings. As one put it, "Physically, the patient who went into the garden became more adapted to outside activity; he became stronger and more alert." Many patients requested permission to go into the garden.

Rewards of Garden Excursions

The nursing service reported that two of the patients progressed so remarkably that they were transferred to more active wards of the intermediate service. Many patients who went into the garden responded much better to toilet training and did not soil their clothing while they participated in garden activities. Their hygiene improved generally, and they seemed better able to care for themselves.

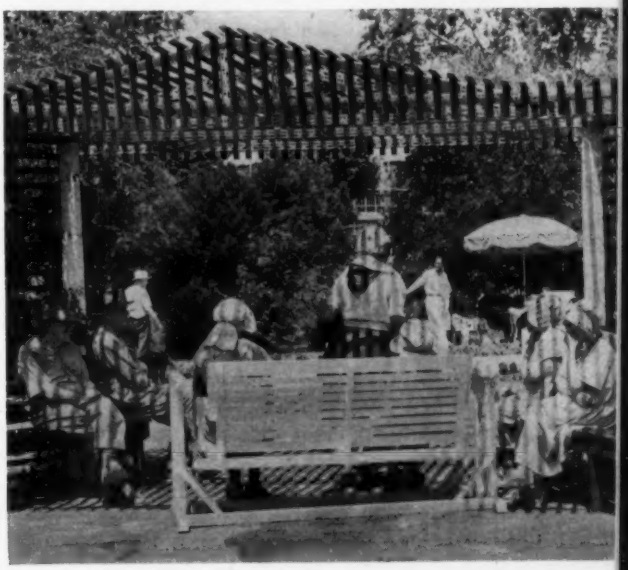
According to our chaplain, "Before the intensive geriatric program was instituted a year ago, it was most difficult to conduct even a song service in the dayroom of these wards because of the noise and disturbed condition of the patients." Now a number of patients express appreciation for the weekly song service and suggest some of their favorite hymns. When we presented an Easter cantata on one of the wards, the chaplain was pleased to observe that "At the end of this musical program, the patients responded with resounding applause." He believes that we have made a good start in our program of reactivation and that all personnel are more aware of greater possibilities in this area of group dynamics.

Access to the garden has also had a decided effect on increasing the number of relatives who visit patients. During the summer months, many of the patients have daily visitors and hold small family picnics in the garden.

Friendship Garden's maintenance costs are very low, and even though data are inconclusive concerning its benefits to our patients, we have seen for ourselves that it is producing noticeably positive results. We are certain of at least one statistic—$3,000 is an inexpensive down-payment for the happiness of our patients. •

Hospital personnel attend patients in the garden. They report heartening changes in the old people's attitudes.

Patients find age and illness easier to bear as they drowse, chat, dream, or observe others in the sunny, quiet garden.



WHAT IS PERMISSIVENESS?

By ROGER REGER, M.A., *Director*
Special Treatment Center
Wayne County Training School
Northville, Michigan

Is it better to be "permissive" or "directive" in working with patients? Those concerned with this practical problem sometimes forget that permissiveness and directiveness are not absolutes, but are relative concepts. What is considered permissive in one setting might very well be called directive in another. The personnel in treatment centers must approach this problem by deciding exactly what the needs of the patients are.

At our Special Treatment Center, we made an attempt to isolate the exact meaning of permissiveness. This is a self-contained unit for 26 emotionally disturbed, mentally deficient boys, ranging in age from 10 to 14. The cottage unit contains a teaching staff, psychological and social services, OT facilities. and living quarters for patients.

We now recognize that there are certain explicit policies and rules which everybody must follow. Thus the personnel working in the school, in the occupational therapy shops, in the cottage, and in individual and group psychotherapy sessions are quite directive about the general procedures and limitations. Within the framework of these general boundaries which are clearly understood by staff and children, the workers heartily encourage permissive attitudes.

The Implicit Made Explicit

This is different from our past approaches. What was always known implicitly has now been spelled out explicitly. We recognized that many previous techniques which we called "permissive" were really nothing more than our tendency not to decide what should be condoned and what condemned until we were forced to do so. Using the slogan "testing the limits," we permitted the children to interact with the adults until each found the optimal distance in their mutual relationships, whereupon the employee said, "Stop! Enough!" At that point, employee and child knew what to expect from one another, but the trouble was that each employee, each child, and each day brought new tests of these expectations, which often resulted in a certain amount of misunderstanding and discomfort.

The method of room assignment affords a good example. Under the "permissive" approach, we had no set procedure as to how room changes were to be made. The children themselves, the therapists, or the cottage staff initiated requests; sometimes the therapist made the decision because of therapeutic considerations; at other times, the cottage staff decided. Eventually we asked the question: When changes are made, what are the reasons for them? Certainly reasons were not explicitly understood by anybody. We had almost reached the point where we considered leaving a child in the first room he was assigned to, but since the boys often remain in the cottage as long as two years, this would have been an impractical solution.

We finally decided to allow the children to make room changes every three months and to decide among themselves which rooms and roommates they wanted. The tempest in the teapot subsided. The children planned ahead for their new room assignments in the knowledge that they would have to live with their choice for a definite period. Implicit rules and opinions had been consolidated into an explicit policy, and everybody knew what the policy was.

The first step toward permissiveness is to make overt rules and expectations which may be covert. Thus it is possible to define permissiveness as the encouragement of individual expression within the structured boundaries of rules and policies explicitly understood by the community of patients and staff. ●

Have You Heard?

NURSING—The White House has announced the formation of a 22-member consultant group to study ways of alleviating this country's nursing personnel shortage. After obtaining advice from physicians, hospital administrators, nurses, educators, social workers, and public health executives, the consultants will help to devise a program to meet the nation's needs. Dr. Alvin C. Eurich, vice president of the Ford Foundation's Fund for the Advancement of Education, will be chairman. The group is expected to file a report with the Public Health Service by January 1, 1962.

- According to the National League for Nursing, Inc., U. S. schools of professional and practical nursing admitted an estimated 73,565 new students during 1960, compared to 71,297 in 1959. The 1,152 professional nursing programs offered in hospitals, colleges and universities, and junior colleges admitted 49,787 new students in 1960—an increase of almost 2,000 over the previous year. Estimated admissions to practical nursing programs increased from 23,500 to 23,778 during the same period. There were 661 such programs last year, compared to 607 in 1959.
- "Dilemmas in Nursing" was the theme of the Fourth Annual Western Conference on Nursing Education held in March in Los Angeles, under the sponsorship of the Western Council on Higher Education for Nursing. In summarizing the conference, Mrs. Lulu Wolf Hassenplug, Dean, School of Nursing, UCLA, presented four pertinent facts: (1) The shortage of nurses is here to stay, and for some time there will not be enough high caliber faculty members to go around. (2) There will be an insufficient number of quality nursing service supervisors. (3) Nursing is moving into a diversified system of education—a fact which must be faced and honored. (4) Continuation education is now available to nurses employed in teaching, supervision, and administration throughout the western United States.

OPEN-STAFF POLICY—The Board of Directors of North Shore Hospital, Winnetka, Ill., recently established an open-staff policy which enables any patient to have his personal psychiatrist treat him, utilizing hospital facilities. North Shore is a 100-bed private psychiatric hospital with one psychiatrist for about every eight patients. The new policy will improve the ratio since the hospital will be available to any licensed psychiatrist who becomes a staff member. The program will aid therapy by providing a prime requisite of treatment of emotional disturbances—avoiding interruption of the rapport established between patient and psychiatrist.

GRANT TO WICHE—The National Institute of Mental Health recently granted funds to the Western Council on Mental Health Training and Research of the Western Interstate Commission for Higher Education for a three-year program of interstate cooperation in staff development for state mental hospitals and state schools and hospitals for the mentally deficient. The new program will have three basic elements: (1) a series of regional conferences on selected topics, such as personnel administration, development of inservice training programs, techniques for individual patient-care, and hospital-community relationships; (2) opportunities for staff to visit institutions to observe and work with selected approaches to patient-care and staff development; (3) continuation education activities, bringing university-level short courses, workshops, and conferences into the institutions several times a year.

MENTAL RETARDATION INSTITUTE — Governor Rockefeller has announced that the New York Institute for Research in Mental Deficiency, a new independent center for basic research in mental retardation, will be established on Staten Island. The new institution, believed to be the first of its kind in the world, will have clinical areas containing small wards, as well as facilities for occupational therapy, recreation, classroom instruction, and laboratory research in a number of scientific disciplines. The institute will be located adjacent to Willowbrook State School which will provide a broad range of cases for study.

FACILITIES FOR THE MENTALLY RETARDED IN CANADA—A $1,000,000 building campaign appeal began in April for a five-year building program for the mentally retarded. The appeal is sponsored jointly by the Metropolitan Toronto Association for Retarded Children, the York Township Association for Retarded Children, and Lorimer Lodge, a residence for retarded young women. Harold R. Larson, president of the National Life Assurance Company of Canada is general chairman.

Included in the program will be more special schools, sheltered workshops, and other facilities for retarded children in metropolitan Toronto; a 10-room branch school and child-training residence in Scarboro; an eight-room school in Etobicoke; a new wing for the day school run by the York Township Association; an annex to Lorimer Lodge; a residence for girls 10 to 14; and renovation of adult workshops and social service and administration offices.

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*Shovlain, F. E.; Brown, R. W.; Delaney, G. A.; and Lelli, F. P.: Hospitals *33*:61 (June 1) 1959.

Have You Read?

THE NURSING SHORTAGE: REFRESHER COURSES MAY BE THE ANSWER—by Lillian F. Garrity, in the June 16, 1961, issue of *Hospitals,* the Journal of the American Hospital Association. Nursing officials at the University of Florida Teaching Hospital and Clinics, Gainesville, sought a possible solution to the local shortage of nurses by offering refresher courses for inactive registered nurses. They found recruitment to be simple and initiated instruction as part of the inservice education program. Two of the 29 retired nurses who took the courses have returned to full-time and one to part-time nursing; five have joined the registry and are doing private-duty nursing; five others plan to return to work soon.

THEY'RE LEARNING TO LIVE AGAIN—by Annie P. Findley, June 1961 issue of *The American Journal of Nursing.* A group of 136 severely regressed male psychiatric patients, aged 27-59, had been hospitalized for an average of 12 years. The problem of how to remotivate them was paramount. The hospital personnel seemed to want to participate in an active therapeutic program, but required guidance in channeling and applying their energies. Under the leadership of the head nurse they developed a program which changed the entire milieu of the unit. The unit, previously considered a locked ward, adopted an open-door policy.

Patients are now taking the initiative to try to solve their own problems. They are making their requests known and are striving for their place in society.

REPORTS IN PSYCHOTHERAPY: INITIAL INTERVIEWS—Report No. 49, Group for the Advancement of Psychiatry. This report is concerned with principles rather than techniques. It is based on a consensus of current clinical experience in psychotherapeutic practice and is intended for educational purposes—not training.

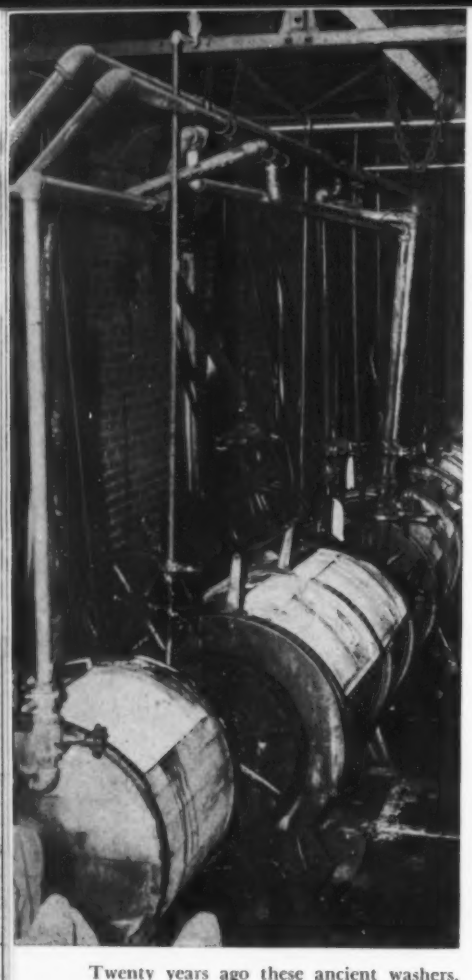
"Speaking generally, . . . we can say that the initial psychiatric interviews have multiple aims. We believe that the most important of these aims is to establish a special kind of relationship with the patient which will permit sufficient understanding to make a diagnosis, to evaluate therapeutic possibilities, to formulate tentative goals of treatment, to recommend a therapeutic program, and to prepare the patient, and his family when necessary, to accept such a program." Available from the Publications Office, GAP, 104 East 25th St., New York 10, N. Y. Single copies, 40¢.

WHAT ARE THE FACTS ABOUT MENTAL ILLNESSES?—by the National Committee Against Mental Illness, Inc., Washington 6, D.C. This pamphlet presents significant statistics on mental illness in the United States. Some of the topics for which data are given are: number of people with various kinds of mental illnesses, number of hospitals and clinics and number of patients in them, age groups most affected with various mental disorders, costs of mental illness, research activities, reduction in numbers of institutionalized patients, standards for and present conditions of patient-care, psychiatric personnel, and needs in mental health.

CARE OF THE MENTALLY ILL IN THE COMMUNITY—by Lewis Clein, M.D., supplement to the May 1961 issue of *Canada's Mental Health,* published by the Mental Health Division, Department of National Health and Welfare, Ottawa, Canada. The author reviews the rapid spread of community treatment services, run either completely independent of or in conjunction with the mental hospitals in Britain. "There has been an increasing emphasis in psychiatric practice in Britain since the Second World War in the development of social psychiatry both inside and outside the walls of the mental hospital."

HEALTH ORGANIZATIONS OF THE UNITED STATES AND CANADA: NATIONAL, STATE, AND REGIONAL—published by the Graduate School of Business and Public Administration at Cornell University. This new volume lists almost a thousand national and regional organizations and many hundreds of statewide voluntary associations, professional societies, and other groups concerned with health, medical, hospital, pharmaceutical, and related fields. The details for each national and regional organization include address, names of principal officials, purposes and objectives, finances, programs and activities, publications, prizes and awards, meeting dates, and affiliates. There is a detailed subject index of all the national and regional bodies. Available from the Publications Section of the Graduate School of Business and Public Administration, Cornell University, Ithaca, New York. Price: $10.

EFFECTIVE MEDICAL WRITING—published in *The New Physician,* March 1961. This article includes seven papers originally presented at the Conference on Effective Medical Writing held at the 17th annual meeting of the American Medical Writers' Association in Chicago, Ill., November 19, 1960.



Twenty years ago these ancient washers, defying workers' attempts to repair them, ruined more laundry than they cleansed.

Today, the washers bear little resemblance to their ancestors. Newspaper articles, stirring public interest, helped the hospital to get more and better equipment.

A Laundry Evolves into a Therapy Center

Patients, working in the modern laundry, regain confidence in holding a job and doing it well. Nearly 50 per cent of them adjust successfully after discharge.

By Mrs. BERTA M. OLIVER
Laundry Manager
Eastern State Hospital
Lexington, Kentucky

OUR LAUNDRY had to come a long way to be considered one of the hospital's rehabilitation facilities. In the beginning, its personnel had to struggle to make it function at all. But today, in addition to its obvious purpose, one primary goal of the laundry department of Eastern State Hospital is to restore patients to the community at the highest level of social adjustment they can achieve.

To evaluate our future function would be to predict the hospital treatment program, and no one can do that now. However, one thing is certain: more and more of *all* Eastern State's departments are being centered around the treatment of patients. In any case, we are still too engrossed in our present accomplishments and awed by our defeat of past vicissitudes to be visionary. We only know that anything is possible. Our history proves it.

The laundry plant building was constructed in 1906. I don't date that far back, but one employee, who was working here in 1915, remembers using old-fashioned hand irons which were heated on racks that encircled potbellied stoves.

When I came in 1933, we had three washers; one had a deteriorated wooden cylinder, and two had worn-out brass cylinders. It was standard operating procedure for a slat to fall out or for a hole to break open in the brass cylinders and let the clothes come tearing out into the hull. Some of the laundry was ruined, and repairs had to be done by hand, inch by inch, inside the recalcitrant equipment.

We had belt-driven machinery and were constantly lacing belts or putting them back on the pulleys. We still had to finish the laundry with hand irons, but at least they were heated with gas by that

time. Each ironer had two irons, a gas plate, and an "S" hook on her ironing board with which to dip overheated irons into a water bucket on the floor. The clothes frequently emerged from this treatment burned, soiled, or scorched, and it wasn't unusual for us to rewash a garment several times before it was presentable.

We had an old, cylinder-type flatwork ironer that was nothing but trouble; the gears were so badly worn that we had to keep a broom handle within reach to give them a push or a good whack to get the correct amount of ironing pressure. This was a six-roll ironer which demanded clean covers on each roll each week and new padding twice a year. We, of course, were the ones who had to "dress" the fastidious machine.

We had one small tumbler dryer for fluff-drying employees' bath towels. Patients didn't enjoy the luxury of bath towels in those days, but used roller towels. Their clothing had to be hung on racks and pushed into a "dry house"—a four-section room with two iron racks for each section, a steam pipe, and two ceiling fans that circulated hot air. When the overalls, unionalls, and strait jackets dried, they were so stiff they could stand alone. Imagine wearing something like that next to your body! Very few patients had underwear in the summer, and those who wore unionalls *never* had underwear. Once a week we washed straw ticks; there may have been a few mattresses, but very few. Patients brought in all the laundry from their wards, and, when it was processed, they carried it back.

Supervisors assigned patients to work in the laundry wherever they were needed, or sent them to us with instructions to make them work. If the patients refused, they were sent back to the ward and punished. We didn't have tranquilizers in those days.

Desirable Metamorphosis

It was not until 1939 that laundry conditions began to improve. When news reporters and photographers stirred up public interest by explaining and illustrating our problems in the papers, we received three washers, one extractor, two tumblers, a shirt unit, twelve presses, and—to the delight of all—twelve electric irons and new ironing boards.

By 1947, laundry volume forced us to add two more washers, two tumblers (by then we had bath towels for patients), one extractor, and a new eight-roll, chest-type flatwork ironer. (Now we could throw away our broom handle!) We switched to a different kind of covering on the flatwork ironer; it lasts for over two years, and the factory man installs it. In 1954, the use of hospital linens and patients' clothing increased so much that we added another tumbler and an extractor. We got three more press units in 1957.

This year, the Victor Kramer Company, Inc., lanundry management consultants, made an extensive survey of our laundry. Heeding the consultants' recommendations, the Department of Mental Health purchased six new presses and an air compressor.

In 1955, the hospital established an industrial therapy department. A year later, the laundry became one of the department's chief adjuncts where the laundry manager and therapists train patients for jobs in the community. Ward doctors select patients for industrial therapy, and the therapist decides which patients should be assigned to the laundry. Since the program began, an average of 67 patients have worked in the laundry each day. Nearly 50 per cent of them have adjusted successfully to jobs in the community.

One male patient was quite sick and unwilling to work when he first was assigned to the laundry. After a few days, however, he became interested and helped with anything he was asked to do. He soon adapted to the situation and assumed the responsibility expected of any employee. The hospital discharged him four years ago; he began a regular job and has adjusted satisfactorily to community life.

A woman patient approached her work as a hand ironer with a better attitude than the man had displayed because, evidently, she had done similar work before. She kept a record of the number of pieces she ironed each day and considered herself an employee—not a patient—although she never asked for a pay check. She left the hospital five years ago and is now employed in a rest home where she is getting along fine.

Multiple Therapeutic Purposes

Although several patients have been trained for and later obtained specific jobs in local laundries, the primary purpose of industrial therapy in our laundry is to teach the patients to be responsible for any job they might obtain. The laundry stimulates them to develop good work habits, self-confidence, and acceptable social behavior—all of which are important in any job situation.

Working relationships are exceptionally good between laundry personnel and patient-workers. Employees appreciate the patients' assistance and strive to help them improve and become self-supporting. Each year, we hold special employee-patient events, such as Christmas parties and picnics. We specifically plan these activities for the patients, but their purpose is to further congenial and productive relationships between personnel and patients.

Today, we take pride in the results of our laundry's industrial therapy and in being able to return all patients' clothing—both state-supplied and home-furnished—in a cleaned and pressed condition. We have more time for patients, more equipment to meet their needs, and plans for the future which include dry cleaning equipment to provide better service and permit greater variety in patients' clothing. Our hospital has a 100 per cent open-door policy; this calls for ever-increasing improvement in our patients' well-being and personal appearance. Our laundry expects to respond to both of these needs. •

Per Capita Cost Data — Comparative Question Mark ?

By CARL E. APPLEGATE
Formerly Deputy Director, Administrative Services
California Department of Mental Hygiene
Sacramento, California

FOR A LONG TIME, MENTAL HEALTH ANALYSTS have used per captita cost figures, expressed in daily, monthly, or yearly cost for the care of patients in mental hospitals, as yardsticks of comparison between patient services rendered by the different states.

"Thirteen Indices" and "Fifteen Indices," publications of the Joint Information Service of the American Psychiatric Association and the National Association of Mental Health, present the daily per capita costs for each state, ranking the states according to their individual per capita cost for the years 1956, 1958, and 1959. The National Institute of Mental Health, in its series of reports entitled "Mental Health Statistics," shows the average per capita cost for all states and the yearly per capita cost for each state.

Per capita cost is considered an index to the quality and quantity of services a state furnishes its mental patients. The impression is that a state with a higher per capita cost gives better service. Unfortunately, it is likely that these figures are misleading because of monetary and statistical differences in the state accounting systems. While per capita costs tend to be a rough estimate of the type of mental health care in a given state, they are not sufficiently accurate for valid comparative purposes.

There are many reasons why per capita cost figures are not comparable between states. The period of inflation this country has experienced since the war, and the ever-mounting per capita cost figures, prove that the dollar has no constant value over a period of years. Likewise, actual operating costs vary according to geographic locations; climatic conditions and economic differences between communities cause relatively higher or lower expenditures for maintenance, heating, construction, etc. Salary levels and working time for employees vary. Some hospitals get help at no cost from patients. Others, such as the Veterans Administration hospitals, have very little unpaid patient-help.

Comparison Bases Differ

Some hospitals have farms, and the method of charging hospitals for their products differs among the states. Outside payment for the care of patients may or may not be credited to the ward operating costs of a hospital. Similarly, capital outlay expenditures may be provided by bond issues or by appropriations, and the method of charging such costs to operating expenditures varies among the states. It is obvious, therefore, that although the figures seem to have approximately the same bases for comparison and are gathered in a similar manner, the basic foundations for them actually are different.

A yearly per capita cost figure may be calculated for each hospital within a state system. This is a useful administrative tool in comparing types of service rendered within a state system and, for legislative budgetary purposes, to determine changes in year-to-year costs. Even so, comparative per capita costs of individual hospitals may vary considerably due to the size of the hospitals, types of patients cared for, and climatic locations within a state. To determine an over-all per capita cost for a state, it is preferable to calculate a single yearly per capita cost for all hospitals within the state system, including the central administrative office.

Those interested in the administration of mental hospitals have recognized for years that per capita costs are not dependable in making true comparisons between all states. As early as April 1953, I presented a paper on the subject at a meeting of hospital administrators and statisticians in Washington, D.C., which was sponsored by the National Institute of Mental Health.

Subsequent meetings of this group resulted in the formation of a Conference of Mental Hospital Statisticians. At their 1958 meeting, the group appointed a committee to work with state finance officers and the Council of State Governments "to develop more meaningful reporting of expenditure data." In 1959 the committee made a progress report of their work and suggested that a grant be secured to make a complete study of the subject. At the 1957 Mental Hospital Institute in Cleveland, Dr. John J. Blasko presented "The Fallacy of the Per Diem," and led discussion on the topic. His reasons why a per capita cost figure should be taken with a grain of salt are detailed in the February 1958 issue of *Mental Hospitals.*

New Measurement Systems Needed

If a per capita cost figure is not a true measurement of hospital service (it will never be unless all accounting systems in the states are made uniform), what system can be devised for a better comparison of services to patients?

One possible method of measurement would be to compare the number of man-hours of service per patient per year. To calculate this, employees in a hospital would have to be segregated according to function, i.e., administrative—food service, maintenance, farming; and medical—doctors, nurses, and attendants. The total yearly man-hours for each function and for the hospital as a whole would be determined and then the number of man-hours per patient.

This approach would equalize the pay scales, hours of work, and economic conditions across the country. Since salaries constitute about 70 to 75 per cent of operating costs, the man-hour-per-patient-per-year formula would show a comparison of the major costs of operating a hospital. It would not cover the hospital's expenditures for food supplies, fuel, farming equipment, and other supplies and equipment. These might be covered by a more uniform nationwide system of accounting such costs in the expenditure ledgers or by using an adjustment factor to alter these expenditures based on the economic conditions in various sections of the country.

Another possible system would be to develop a per capita cost based on the number of patients treated during a year's period rather than on the average resident population. Some states have larger allotments of treatment personnel than others and, therefore, are able to treat and release patients faster. Under such circumstances average daily resident population is not a proper factor to divide into the total operating costs to arrive at a per capita cost. Instead, the total average resident population plus the number of patients admitted in a year's period divided into the total expenditures would show the average cost of treating and releasing a patient.

There may be other more acceptable methods of determining comparative costs between the states. However, perfecting them would require study and revision of the states' accounting systems so that comparable data would be used by each state in arriving at a per capita cost factor.

Tackling the Problem Practically

A few organizations are studying this problem, but their work is incomplete. The Council of State Governments has discussed the problem during its meetings. The Model Reporting Area, a conference of mental hospital statisticians representing 22 states and sponsored by the Biometrics Branch of the NIMH, considered the problem at a meeting in 1958. In 1959 it appointed a committee which reported on per capita cost methods at the Model Reporting Area's annual meeting.

It seems to me the NIMH would be the logical body to develop a comparative cost system, either on a more valid per capita cost figure than present ones or by any other method of relating treatment costs which would serve as a true comparison between states. To undertake such a study would require a dedicated committee capable of suggesting changes in accounting procedures and methods of collecting data. The study also would require considerable time and money. Perhaps the NIMH could give a grant to the committee or organization performing the work.

This study might develop a method which would compare adequately the costs of mental hospital operations throughout the United States. Then the comparative data developed could be relied on by national organizations and the various states as a true measurement of treatment and care. •

"Fimble, I want you to quadruple our outpatient facilities. I don't care how you do it, just as long as you don't spend any money."

"You haven't seen a 675-bed hospital lying around, have you?"

Serving "Select" Meals in Mixed Company

A hospital "opens" another door and allows men and women patients to dine together from a selective menu.

By RUTH VAN ANDEN, *Supervising Dietitian*
Hudson River State Hospital
Poughkeepsie, New York

FEW THINGS ENHANCE a patient's personal freedom more than being able to choose his own food and the companions with whom he would like to dine. We have made a start in this direction at Hudson River State Hospital by allowing men and women patients to eat together and giving them at least a second choice of food on the daily menu. As a result, greater socialization takes place between patients. Men often assist women with their trays, and the patients' personal appearance have improved tremendously. Men, especially, take more pride in their clothing and personal grooming.

The project began in a building which houses some 450 patients in eight wards, four for men and four for women. Previously, women ate in a dining room on the first floor and another on the second; men ate in a separate room on the second floor. Each dining room seats 80 people and is furnished with formica-top tables set with vases of artificial flowers and salt and pepper shakers. Colorful draperies decorate the windows and walls, and each area is furnished with a steam table, coffee urn, and electric toaster.

We began the new dining arrangements by assigning one ward of about 55 men to eat with the women in the first-floor dining room. This proved so satisfactory that two weeks later we permitted another ward of 50 men to eat in the same dining room. We extended meal periods to allow for leisurely eating; before, all dining areas served simultaneously, beginning and ending at the same time. We also provided ash trays for after-meal smoking.

Instead of counting patients as they entered the dining room, we gave each one a tag to present to a ward employee after picking up a tray from the cafeteria counter.

Patients Respond to Relaxed Dining

Soon the congenial and relaxing atmosphere that developed on the first floor encouraged us to integrate the dining rooms on the second floor. These accommodated 130 women and 120 men who were not quite as comfortable as those downstairs and needed more supervision. We decided to alternate the women's ward and the men's ward, allowing about 40 of each sex in the dining rooms at the same time. The results were excellent. Eventually, greater socialization took place among these patients than those on the first floor.

At the end of this first phase of the program, it was obvious that the dining rooms were much quieter and the patients were more friendly and relaxed during meals. In addition, the food service was able to close one of the dining rooms and concentrate its employees on the other two for better service.

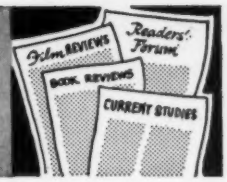
Then, as planned, we introduced a selective menu to give the patients at least minimal freedom to choose their own food. To accomplish this without increasing the food cost presented a problem, but we found we could do it by interspersing different food items on the menu each week. Instead of giving a full issue of one food item once a week, we served half issues of two foods twice a week.

At breakfast, we offered a choice of fruit or fruit juice and a choice of cooked or prepared cereal. Later, we discontinued the prepared cereal on a regular basis because our food budget would not allow us to serve cornflakes more than twice a week. For dinner and supper, patients had a choice of vegetables, salad, and dessert. We are still trying to give patients a choice of entree, which they would like very much, but we can do this only when the ingredients of the choices are the same, such as sliced corned beef and potato salad as an alternate for corned beef hash or salmon and macaroni salad as a substitute for baked salmon and macaroni. Future plans call for a selection of entrees.

We noticed that the last patients to eat often did not get a selection because the more popular food of the day was gone by the time they ate. However, we solved this problem by checking the patient-acceptability of all food items and then pairing two equally attractive dishes.

We encountered no other problems in integrating our patients or in preparing the selective menu. Of course, we had to change from compartment trays to individual dishes and prepare additional food, but the satisfaction of the patients more than compensates for our extra efforts.

Reviews & Commentary



FILM REVIEWS

The films reviewed below will be of special interest to mental hospital personnel who are responsible for training programs. It is expected that both will be shown at the 13th Mental Hospital Institute in Omaha.

UNDERSTANDING AGGRESSION (black and white, 23 minutes). Produced by the Ministry of Health, Great Britain. For rental and purchase information, write to Contemporary Films, 267 West 25th Street, New York, N. Y.

This interesting film, set in a small English mental hospital, centers entirely on psychiatric nurses and aides and their problems in handling aggressive patients. The story opens with a short scene in which a psychiatrist lectures to a class of nurses and aides about the nature of aggression. He even shows films illustrating how children handle hostile feelings. After the class, for no apparent reason, a nurse is attacked by a disturbed woman patient. At a cricket match, the nurse's male counterpart in the story also experiences violent aggression from a male patient. Later, at a staff conference, the nurse and aide discuss these events and try to find out why they occurred.

The psychiatrist reconstructs the histories of each of the two aggressive patients and offers possible explanations of why the attacks occurred. The nurse and aide who were the objects of the hostility fill in the gaps and, eventually, come to understand that the aggressive acts were not meaningless. In one case, the aggression was related to the aide's own feelings about the patient. The film closes with the entire group discussing better ways of handling aggressive behavior.

Although the story is necessarily somewhat pat, "Understanding Aggression" has many good features. Explanations of the patients' behavior are psychodynamically sound and are clearly presented. The staff conference scenes are especially interesting because of their informality and the extent to which the aides reveal their own feelings and fears about aggressive patients. Another virtue of the film is that it does not convey the impression that *all* patients are aggressive.

American audiences will be fascinated by this glimpse of English mental hospital life. This film could be useful in training programs to help mental hospital personnel understand their own behavior as well as that of the patients. It would also interest students of medicine, nursing, social work, and psychology.

MEDICAL USES OF HYPNOSIS (black and white, 28 minutes). Produced by Robert Anderson. For information about availability, write to International Film Bureau, 332 S. Michigan Avenue, Chicago 4, Ill.

Hypnosis as a psychiatric procedure is attracting a great deal of public and professional interest these days. For evidence of the public's enthusiasm, see almost any popular magazine. For the definitive medical stand, see the concise statement prepared by the American Psychiatric Association's Committee on Therapy. Despite a few deficiencies, this film is an excellent brief survey of the medical potentialities of hypnosis, showing its use to anesthetize, to alleviate neurotic symptoms, and even to stop smoking! There is an interesting historical account of the ups and downs of hypnosis since Mesmer's day, illustrated with contemporary engravings.

The case material is presented through Robert Anderson's smoothly handled interview of Dr. Nathan Schechter and some of his patients. One interesting case is that of a pregnant woman who was helped to understand that her excessive spitting meant rejection of her unborn child. A patient suffering from asthma, and one with a skin condition, also describe how they were helped. The dangers of improper use of hypnosis are mentioned, although they might have been underscored more heavily. For example, no reference is made to the spontaneous hypnotic state.

A scene showing the use of hypnosis to anesthetize a woman undergoing a difficult eye operation is definitely not for the squeamish (as the narrator warns). Since this scene contributes little, one wonders why it was included. In general, however, the film's approach to hypnosis is unsensational and scientific; hypnosis is never suggested as a replacement for other medical procedures.

The film was shown to the general public in Canada via television, but this reviewer believes that its best use would be with students and hospital personnel. It does a good job of counteracting the slightly raffish reputation that hypnotism seems to have acquired and (if you avert your gaze during that eye-operation sequence) it is a thoroughly enjoyable and informative experience.

JACK NEHER
Mental Health Materials Center

BOOK REVIEW

THE SOCIAL EPIDEMIOLOGY OF MENTAL DISORDERS—by E. Gartly Jaco, New York, Russell Sage Foundation, 1960, 228 pages, $3.50.

This is a gem-like contribution to our knowledge of the extent of mental illness. It is well-planned and flows like the movements of a fine symphony. The author presents a study of the incidence of psychosis in Texas during 1951 and 1952. Most studies are made of cities; only two cover such a broad area.

During the survey period, the population of Texas was about eight million. More than 11,000 cases of psychosis were found—an annual average of about 5,650. This gives a crude annual incidence rate of 73 psychoses per 100,000 general population.

The psychotics, diagnosed by qualified psychiatric personnel and very carefully defined, were residents of Texas. Only patients who sought treatment for the first time during the study period were included. An important feature of the survey was that it covered private cases as well as those receiving public care.

Rates were calculated specifically for age groups and for sex. They were also calculated for the three subcultures of Texas (Anglo-American, Spanish-American, and Non-White). An important finding of the work is the demonstration that rates must be adjusted for the subcultures.

Other characteristics of the population that were analyzed included marriage, occupation, education, urban-rural residence, spatial distribution, and migration. The author reports that "with the exception of interstate migration, statistically significant differentials were exhibited by the psychotic population in all of the . . . characteristics investigated."

Findings differed in special respects from other similar surveys. Two interesting differences were: (1) the higher psychotic rates among professional and semiprofessional occupational groups, and (2) the equally high rates of psychoses among those who attended college and among those who had no education.

This is a model study of its kind. It will be welcomed by epidemiologists, public health psychiatrists, and those who face the responsibility of planning for treatment of the psychoses.

MORGAN MARTIN, M.D.
Chief, Mental Health Division
Department of National Health and Welfare
Ottawa, Canada

From Canada's Mental Health, April 1961. Reprinted with revisions by permission of the reviewer.

READERS' FORUM

"Maximizing Therapeutic Inefficiency"

Several of us at this VA hospital read the article,"Maximizing Therapeutic Inefficiency," by Standford H. Simon in the April issue of *Mental Hospitals.* Since we found it so delightful while at the same time so pertinent, we desire a distribution of the article to other members of the staff and to the personnel of the hospital. We would like permission to reproduce the article in the printing shop of the hospital here and to distribute the copies. Should you grant this permission the article will not be changed in any way and there will be no profit involved. The copies will be given to nurses, aides, and physicians.

RALPH T. HUMMEL, M.D.
Pittsburgh, Pennsylvania

By-line Error

I would like to point out that the article "Laboratory for Practical Rehabilitation," which appeared in the April issue of *Mental Hospitals* under my name, was co-authored by Stephen J. Golburgh, Ed.D., instructor in Psychology and Guidance at Boston University.

WILMOT D. GRIFFITH
Massachusetts Mental Health Center
Boston, Massachusetts

Paper Pleases Podiatrists

I have just read Dr. J. A. Conforti's paper, "Foot Care for Mental Patients," in the March issue of your magazine. As I am a podiatrist on the staff of the North Dakota State Hospital at Jamestown, this article was of very great interest to me.

As president of the State Board of Podiatry Examiners of North Dakota and of the North Dakota Podiatry Association, I have been asked by the membership to write and thank you for the publication of this article. We feel that in publishing it you have immeasurably aided a portion of the medical field: too many people with "minor" foot ills are left unattended. You are to be complimented for your efforts on our behalf. I know we will justify your interest in us now and for many, many years to come.

Dr. J. E. O'Brien, the executive secretary of our state association, would much appreciate a dozen reprints of Conforti's article.

T. W. COCKRELL, D.S.C.
Minot, North Dakota

Healthy Sibling Rivalry!

I call the attention of your readers to "Nurses and Psychotherapy" which appeared in the May 1961 issue of *Mental Hospitals*. Jacqueline Bernard is to be congratulated on a fine piece of work. The kind of experimental endeavor which she instituted and described, besides being quite consistent with the message of the Final Report of the Joint Commission on Mental Illness and Health, is an example of the progressive and restless spirit which characterizes our mental health program here in Minnesota.

Mrs. Bernard is not correct in stating, however, that Willmar State Hospital is better staffed than her own Anoka. Actually, according to some standards which we established ourselves and which are roughly comparable to those of the APA, Anoka is 77 per cent adequate in staff-patient ratio, whereas Willmar is only 69 per cent. Anoka, it is true, has an active medical-surgical program which drains personnel; on the other hand, Willmar has an active alcoholism program admitting 1,700 patients a year over and above its 1,000-bed general psychiatric service.

I do not send this information to embarrass Mrs. Bernard and the good people at Anoka, but to set the record straight. It also gives me opportunity to mention with quiet pride that Willmar is now 100 per cent open, which proves that a hospital can be opened with limited staff. This achievement is to be credited to Dr. Vera Behrendt, the superintendent of Willmar and to her predecessor, Dr. Nelson Bradley. You can be sure that we will have similar announcements to make as our hospitals, one by one, achieve 100 per cent open status.

DAVID J. VAIL, M.D.
Medical Director
Dept. of Public Welfare, Minn.

Hospital Farms—
Ohio Hospitals Take Issue

. . . in rebuttal to the article "The Hospital Farm—Boon or Bane to Patients" (June, 1961) . . .

Several questions are left unanswered as far as I am concerned. How much is it costing for the new vocational rehabilitation program? How many patients are benefiting from the new program? No matter what service is performed, money is involved.

I sincerely hope that it is possible to print the views of our farm manager and food service director. Ohio is currently in the throes of debate over whether to keep the farms or close them. I personally feel that there is a definite place for the farm operation if it is properly organized and supervised.

D. L. FORD
Hospital Administrator
Dayton State Hospital

The mental hospital farm program must be coordinated with the food service department, and only that produce grown which can be used efficiently. Because the weather conditions do play an important part in the production of orchard and garden crops, the food service director needs to keep a flexible menu in order to be able to get the most benefit from the farm. Freezing and canning would help to eliminate waste. An effort is made to harvest vegetables over a period of several weeks instead of overloading kitchen facilities. Those items which can be stored for future use are the most profitable.

In the farm accounting system we are allowed $.026 per pound for Irish potatoes, $.07 per pound for tomatoes, $.04 per pound for picked apples, $.03 per pound for cabbage and carrots, $5.50 per cwt. for whole milk, $.28 per pound for dressed dairy beef, $.43 per pound for dressed veal. Can these foods be purchased on the open market for similar prices? They can be bought, ready for use in the kitchen, but not without paying for the processing and handling.

Certainly more than 3 per cent of the patients in the hospital should benefit from the fresh air and sunshine and physical development on the farm. This type of therapy can be beneficial to many patients—without any consideration of farm production.

On a farm where the livestock receive such good care, it is only logical to assume that the patients get the same good treatment. In our program the patients' welfare comes first. This is where the emphasis should be placed—not on production.

The Virginia hospital retained all of the farm personnel; and since the expense for labor is the big item in operating a farm, it is hard to see where a saving was made. It has been our opinion that almost as much help would be needed to keep the fields in a presentable condition as to operate the farm and harvest the crops.

In times of emergency, such as war, patients of an institution live much better if they have their own farm.

Much of the pressure of farm work has been reduced during the past few years through the use of machinery. Patients are not required to work for any certain length of time but do what they feel like doing; some are busy only one or two hours a day. Over the years we have seen many disturbed patients come to the farm and improve to the point where they were able to go home and stay. Some of them, not familiar with farm operation, have gained much from their experience here.

FORREST F. FROST
Farm Manager
Dayton State Hospital

"The Hospital Farm—Boon or Bane?" written by Mr. Joseph Risk in June's *Mental Hospitals* reflected, in my opinion, a lack of preparedness on the part of the food service department to properly utilize the fresh vegetables received from the farm. Certainly better planning and cooperation with the farm staff would have eliminated most of Mr. Risk's problems. Further along in his article, he complains of unsanitary dish washing. I would naturally assume that problem would be corrected by the food service director.

As a layman, I cannot comment on the therapeutic value of the farm to the patient, so I shall leave that in more capable hands. I am sure that with close cooperation the delivery of vegetables from the farm to the kitchen will not get out of control. On the rare occasions that we have more than we need, we find other state institutions only too happy to receive our surplus.

GERALD H. TAYLOR
Food Service Director
Dayton State Hospital

Over the years *Mental Hospitals* has carried several articles which were very complimentary to agriculture in public mental institutions. The authors of the articles have recognized the therapies derived from agriculture as well as the economic values. Apparently, those articles were written by people who were familiar with the subject about which they wrote.

So far as I can recall, the only articles whose authors seemed to desire to write destructive criticism of institutional farms included the one a few years ago concerning the Little Rock, Arkansas, project, and this last one written by the food service manager Mr. Risk, of Lynchburg, Virginia.

The first article was a clear indictment of the poor management of the institution with the farm becoming the scapegoat. Insofar as Mr. Risk's article is concerned, we, who have spent many years in institutional work and particularly in connection with agriculture, know his thinking.

Mr. Risk knows that it is much easier for the dietary department to work with produce as it comes from produce houses and stores—fresh, frozen, dried, or canned—than it is to prepare food products for table use which come directly from the field, barn, or slaughter house. And it certainly saves work, but not money, when food service people no longer have to conserve foods by canning, drying, or freezing. Many people, including food service employees, do not want to do any more work than they have to.

Agriculturists, psychiatrists, and physicians know the great value of institutional farms. They recognize that agriculture has much to offer in therapy, training, in habilitation, and in the rehabilitation of patients.

GEORGE F. FULLER
Farm Manager
Gallipolis State Institute

Regarding farm training programs, in most institutions for the retarded the patient does learn most all facets of farming that he will need to make a successful adjustment on a community farm. I question whether or not the patient benefits from learning crop

rotation, fertilization processes, and proper uses of insecticides. The patient should be allowed to receive only those experiences which will ultimately benefit him in a community placement situation. I have yet to see a mentally handicapped person being placed into a situation where he will decide on crop rotation programs for the farmer as sort of a "specialist."

If I may refer you to a study published in the July 1959 issue of the *American Journal of Mental Deficiency,* the authors stated: "There is no general trend in the country toward discontinuing institutional farm-dairy operations. On the contrary, most organizations are planning to continue as of this date, including those currently reporting a financial loss. In general, the data indicate that farms and dairies are considered a worthwhile phase of institutional operations."

I have personally been involved in institutional farm-training operations for the past few years and have found that if the farm is properly managed and coordinated into the total institutional picture it serves two main functions: (1) The farm provides excellent, fresh, nutritive food for the patient population, and (2) an excellent training-therapy facility for both the male and female patient population.

Mr. Risk's "Tomatoes, tomatoes, tomatoes" problem is not unique. However, by proper coordination of farm and food service programs as related to market produce to be grown, this problem has been minimized in many progressive institutions.

Food service personnel must realize that nothing replaces farm fresh products as having the highest nutritive value possible. The nutritive value of produce purchased on bids is questionable, related to fresh grown.

If there has been an inconsistency in their program, both in food preparation and patient-care, let us not put the blame on the one area which I feel benefits the entire institution the most—*the farm.*

Farm training programs in institutions have been the most positive training areas for many years, and I am confident that they will continue to be profitable for both the taxpayer and the therapy-involved patient in our more progressive institutions.

A. Z. SOFORENKO, B.S., M.S.
Director of Industrial Therapy
and Vocational Training
Orient State Institute

The following letter was received directly by Mr. Risk.

Your article in the June issue of *Mental Hospitals* is amusing and shameful. It is amusing because it makes so many silly and laugh-provoking statements that even the amateur farmer or gardener would know otherwise. Your article is shameful because it does not till the truth; theerfore, it is a pity to mislead our fellow employees and taxpayers with such malicious journalism.

In the title of your article, the word "Bane" is very misleading. Webster's Dictionary defines "bane" as "that which causes death, ruin or destruction." I doubt if you can find *any* death certificates which list the cause of death of any patient or employee as directly due to farm work—unless it is accidental.

You speak of the bright red tractors, combines mowing and baling hay in neat rows, and large luscious tomatoes and vegetables. For your information, combines don't mow hay, even in Virginia. See what "goofs" you can make when you overstep your limitations? Quite amusing to someone who knows better. This is all very complimentary to any farm manager. At a neighboring institution a year ago, the hospital business office had four calls regarding new equipment that the hospital had purchased for the farm but the truth was that it was old equipment which had been overhauled and painted during the winter months. This was an excellent compliment for the hospital itself and particularly the farm employees.

Your three paragraphs dealing with an excessive receipt of vegetables from the farm is an admission of your own guilt. That is a problem for you and your farm manager to solve and it can be done. We had that very same problem at our institution when I came here three years ago. All that was needed was a few meetings between the diteitian and myself to discuss and iron out some of the difficulties. This was done and both departments have profited.

Then you speak of the fine, showplace, and modern dairy operation. Evidently, you have a good dairyman too. You are critical of all this up-to-date and modern equipment. If you were a positive thinker, instead of a negative one, you would be using the farm's high place on the "totem pole" to elevate your own department but instead you are trying to drag them down to your level. Does misery love company? You must.

What people like you succeeded in doing was to "brainwash" the people of Virginia that the farm was doing a lousy job. It is this sort of thing that is threatening the farm program in other states. Our neighboring state of Michigan made the same fateful mistake as your institution. Last summer when this idea was exposed in some newspapers in Ohio they were bombarded with letters from people from all walks of life, criticizing the removal of the farms in general.

You state that since the farming has been abolished that the farm employees are still working at the hospital but on different assignments so really you have not economized at all. In fact, it is more wasteful than ever because they are not producing any food. I imagine, if we were to hear or see the other side of it, that your vocational rehabilitation gardening program would be on the amusing side.

You speak of the classes for teaching farming. How better can you learn to do a job than by actually doing it?

You state that now the supply from the garden is usually insufficient and that local vendors supply

additional vegetables. How can you honestly justify this to the taxpayers of your state when you still have the land and the employees? All that was done was to increase the costs (a drain on your fellow taxpayers) but you did not reduce the expenses.

Your last statement regarding the "reorganization" may not be reported in the *Progressive Farmer*. That is true because I am sure that they would not regard it as a progressive move.

Your whole article amuses me in that you are such an authority on our farms. This leads me to wonder why you have the title of food service director. Probably you were raised on a farm and that makes you an authority. I would say that if you knew a small portion about your own job, as you claim to know about the farm, that you would be an outstanding food service director in Virginia, Ohio, or the United States. Please, Mr. Risk, try writing an article on food preparation, management, diets, nutrition, or some related phase on which you are getting paid to know something. Or are you afraid to do that?

It is shameful that the magazine used good space for such a negative, ill-advised article.

Thank heavens, we have a practical, efficient, well-informed dietitian who is striving to improve her own department instead of wasting time tearing other departments apart.

For your information, this is my background. I graduated from Ohio State University in 1939 with a B.Sc. degree in agricultural education. I taught vocational agriculture to high school boys for 11 years. I was farm manager at Longview State Hospital, Cincinnati, Ohio, for five years and have been at Toledo for the last three years.

In March, I was elected president of the Ohio Institutional Farm Managers' Association.

J. CARLTON JENKINS
Farm Manager
Toledo State Hospital

EDITOR'S NOTE:

Mr. Risk replies below to various comments made by our correspondents. The editorial staff of *Mental Hospitals* is responsible, however, for the title and illustrations used on this article.

Webster's New Collegiate Dictionary, 1959 edition, defines "bane" as follows: **"bane,** *n.* **1.** That which destroys life; esp., deadly poison; — now only in rats*bane,* hen*bane,* etc. **2.** *Obs.* Murder; death. **3.** Ruin; woe; esp., destroying or ruining cause; source of irreparable harm."[1]

Note that "the earliest ascertainable meaning is placed first and later meanings are arranged in the order shown to be most probable by dating citations and semantic development."[2] The word "bane," therefore, was correctly used in its third and current meanings.

The juxtaposition of contrasting pictures is a de-

vice as common as is the literary one of using words of similar sound but opposite meanings—i.e., "boon or bane." Both techniques were used to illustrate Mr. Risk's basic theme as expressed in his paper: "Each cow had its own private stall—some of our patients slept on mattresses on the floor because of the lack of funds for adequate patient space and beds." Actually, the pictures understated the situation described by Mr. Risk.

The U. S. Department of Agriculture states that the term "combine" is used to describe various pieces of harvesting machinery employed for two or more functions at once; what these functions are depends on the crop being harvested—grain, legumes, vegetables, clover, etc.—and the local climate. The word was substituted for "hay cutters and balers" in Mr. Risk's original paper.

The desirability of the mental hospital farm is one of many controversial issues which deserve exploration in view of the changes taking place in the philosophy of psychiatric care and treatment. *Mental Hospitals* welcomes articles or letters on any relevant topic, presenting any point of view. The editor believes that disagreement is a legitimate and interesting way of exploring issues. "Readers' Forum" was created primarily to publicize such disputes.

The Author Replies

I have read with interest the letters concerning my article "Hospital Farms: Boon or Bane to Patients?" My intention was to give a before-and-after picture of our farm operation.

Referring to the farm's agricultural success, I stated "its productivity was the pride of the surrounding area." We had 123 head of registered Holstein cattle, which brought $46,135 at auction. In 1934, we had 48 milk-producing cows in the herd; each produced an average of 6,730 pounds of milk, with a butterfat average of 205.2 pounds a year. In 1956, we had 80.8 milk-producing cows, with an average annual yield of 12,712 pounds of milk and 464.8 pounds of butterfat per cow. Everybody was very proud of the hospital farm, and considered it one of the finest operations of its kind.

But those who establish the policies for our mental hospitals in Virginia believed that the mission of the mental hospital is to care for and treat the patients, not to operate a farm, however successful. I felt it a wise decision on their part to abolish the farm and dairy operation in all mental hospitals in the Commonwealth.

I did not and do not question the benefit of farming operations at mental hospitals in other states. But I do believe that we are much better off without the farm and that we are able to train as many prospective farm helpers with our vocational rehabilitation gardening program at less expense and with less waste.

Mr. Ford, Mr. Frost, and Mr. Jenkins question the cost of the vocational program. When the farm and dairy were in operation, we employed 15 farmers who supervised from 40 to 60 patients. The vocational program is supervised by two vocational teachers, who train approximately the same number. Of the 15 farmers none were separated from the hospital when the farm was abolished. Some have been assigned to the ground crew caring for the campus, and others are serving in the Security, Sanitation, and Safety Force, which operates for 24 hours a day and which was established without increasing the number of personnel at the hospital.

Our former farm manager is now the Chief of Security, Sanitation, and Safety. He is the only former farm employee who did not receive equal or better compensation when the farm was abolished. I have just been discussing this article with him, and he stated that he thinks the hospital is better off without the farm because of the expenses of the operation.

Mr. Ford states that flexible menu-planning should enable farm products to be utilized. I agree. Our menus are and always have been prepared six to eight months in advance to enable us to take advantage of seasonal vegetables and fruits without monotonous repetition.

Mr. Soforenko questions the disirabiliay, of teaching patients about crop rotation, fertilization, and the proper uses of insecticides, stating "the patient should be allowed to receive only those experiences which will ultimately benefit him in a community placement situation." We at Lynchburg believe that the more a patient can learn, the more useful he will be to any community employer.

Let me ask the authors of the letters who are so critical of my article to visit non-state-operated farms of comparable size in their respective areas. Let them ask the farmers if they could operate at a profit if they were to employ the number of personnel required to operate a state farm. Can these farmers operate their farms in the number of hours required in a state workweek? Can they give the paid holidays, annual vacations, sick leave, and retirement benefits to which state employees are entitled?

In my original article, I stated that the farm and dairy were the showplace of this hospital. Now I am proud to say that the wards, dormitories, nursery, food service, and our beautiful grounds are the showplaces. Some of the former farm land has been given over to the construction of new dormitories. There are no fences surrounding our grounds, and we have an open door policy. In our main dining room, patients are not separated by sex, but by age groups; each receives a full complement of silverware. During the past few years, many people from the U. S. and abroad have visited our hospital, and have commented favorably on the care we give our patients. I believe that this shows that the Lynchburg Training School and Hospital is a progressive institution, and we cor-

[1] *Webster's New Collegiate Dictionary, G. & C. Merriam Co., Springfield, Mass., 1959, p. 68.*
[2] *Ibid., p. v.*

dially invite anyone interested in mental health to visit us.

JOSEPH W. RISK, *Food Service Director*
Lynchburg Training School and Hospital Colony
Lynchburg, Virginia

CURRENT STUDIES

This column lists investigations of interest to mental hospital personnel. Authors have agreed to make copies of their papers available. Requests should be sent to them directly, with 25¢ for postage and handling.

THE SHELTERED WORKSHOP FOR PSYCHIATRIC PATIENTS

This paper is the second report on a patient sheltered-workshop which began operation in August 1957 at the VA Hospital in Palo Alto, Calif. Patients are assigned to the workshop and to a control group by random selection after pairing them according to age, duration and severity of illness, and, in particular, prognostic evaluations. They perform numerous tasks and are paid in accordance with unit production rather than by the hour. Copies of this paper are available from Roy S. Hubbs, M.D., Chief, Continued Service, Veterans Administration Hospital, Palo Alto, Calif.

HOMELESSNESS AS A MAJOR PROBLEM OF HOSPITALIZED CHILDREN

The author reviews the family status of 89 children who, at one time or another during a 40-month period, resided in a recently developed Children's Unit of the Chicago State Hospital. The author analyzes the situations of the chil to their need for homes when ready to leave the hospital, pointing out dren prior to admission in relation differences in the backgrounds of tics. Copies of the complete study the schizophrenics and the neuro may be obtained from Mrs. Mary L. Dunkel, Psychiatric Social Work consultant, Chicago State Hospital, 6500 Irving Park Road, Chicago 34, Ill. (*This paper was presented at the 117th Annual Meeting of the APA in May 1961.*)

EVALUATION OF COLLEGE STUDENTS AS VOLUNTEER COMPANIONS IN A MENTAL HOSPITAL

In November 1958, the VA Hospital in Topeka, Kans., inaugurated a college student-volunteer companion project. The author discusses objective evaluations of the progress of patients in the experimental group as compared with that of a matched group of controls. The paper is available from Harold Feldman, Asst. Chief, Social Work Service, Veterans Administration Hospital, 2200 Gage Blvd., Topeka, Kans.

News and Notes

Governors' Conference Planned

A special two-day Governors' Conference on Mental Health will be held in the fall of 1961 to evaluate the progress made since the 1954 Governors' Mental Health Conference and to discuss some of the broad recommendations of the Final Report of the Joint Commission on Mental Illness and Health. This announcement followed a session on mental health held during the 53rd Annual Meeting of the Governors' Conference in June at Honolulu.

The governors, recognizing that the commission's recommendations involve executive and legislative action on the state level, felt that a second mental health conference was vital, especially in view of the improvements which followed the 1954 conference in terms of training personnel and introducing new treatments which helped to reduce mental hospital populations. They also wish to discuss the commission's proposed formulae for federal, state, and local action to share the financial costs involved.

Indications are that the mental health conference will explore in depth the commission's recommendation that large state hospitals be replaced by a network of intensive treatment centers and other special psychiatric facilities.

Further Institute News

Registrations for the 13th Mental Hospital Institute, to be held October 16th through 19th, at the Hotel Sheraton-Fontenelle, Omaha, Nebraska, already exceed the number received for any previous Institute by this time of the year.

Professor Winifred Winikus, Acting Director of Psychiatric Social Work Training at the New York State Psychiatric Institute in New York City, has accepted the invitation of the Program Committee to lead the group discussion on Non-Medical Care.

Two new panelists have also agreed to take part in the plenary discussion on "Federal-State Relations—Formulae for Sharing Costs," to be held on the last afternoon of

Mental Hospitals Reprint Service

Readers frequently request reprints of articles in *Mental Hospitals* for distribution to others for various educational and informational purposes. The price list and order form below have been devised to simplify the procedure for obtaining reprints. Since it is not economical to reprint less than 100 copies, the minimum price is based on that number. Reprints are exactly the same size as the originals in the magazine and take the same number of pages. Prices quoted include handling and shipping costs. *Please enclose a check or money order for the exact amount with your order.* Delivery will take approximately three weeks.

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the Institute—Thursday, October 19th, at 2 p.m. They are Ralph Robey, Ph.D., Economic Advisor to the National Association of Manufacturers, and Paul Hoch, M.D., Commissioner of Mental Hygiene for New York.

Many discussion leaders have forwarded the names of those who are to act as their recorders during the Institute discussion groups. The recorders who have so far accepted this challenging task are as follows: Charles Buckman, M.D., Kings Park, N. Y.; Edward M. Burn, M.D., Columbia, S. C.; G. Creswell Burns, M. D., Compton, Cal.; Ruth Barnard, M.D., Los Angeles, Cal.; Theodore L. Dehne, M.D., Philadelphia Pa.; Imogene Gobble, M.D., Louisville, Ky.; Mrs. Enid Goldberg, Pittsburgh, Pa.; Harold Halpert, Silver Spring, Md.; Marjorie J. Hook, R.N., Lincoln, Neb.; Frank A. Majka, M.D., Omaha, Neb.; Morgan Martin, M.D., Ottawa, Canada; Leslie Osborn, M.D., Omaha, Neb.; Herman B. Snow, M.D., Ogdensburg, N. Y.; Jack Wolford, M.D., Pittsburgh, Pa.

APA-SKF Fellowships and Awards

Seventeen Vestermark student fellowships were awarded to 12 different hospitals at the May 8, 1961, meeting of the APA-SKF Foundation Committee.

One state hospital each in Illinois, Florida, Idaho, North Dakota, West Virginia, and two in California were approved to receive two fellowships, and one hospital each in Kansas, Kentucky, Ohio, and New York was authorized to receive one.

In addition, the Committee made a grant of $100 to each of 32 senior medical students for his thesis related to psychiatry. A staff physician in California received a grant to take a course in hospital administration at Cornell University, and a grant was given to help support an aftercare program at a New York state hospital.

Hospital-Community Relations

The citizens of Larned, Kansas, have demonstrated with action their support of the Larned State Hospital. The local newspaper, *The Tiller and Toiler,* published an eight-page "Mental Health Special" supplement prior to Mental Health Week, saluting the achievements of the hospital. Local merchants financially supported the supplement. Its headline, "LSH—Truly A Treatment Center," reflects the community's understanding of the hospital's purpose.

PEOPLE and PLACES

CALIFORNIA: **G. Y. Abe, M.D.,** the new superintendent and medical director of Metropolitan State Hospital, succeeds **Robert Wyers, M.D.,** who has retired.

QUARTERLY CALENDAR

APA ANNUAL MEETINGS

1962 May 7-11, Royal York Hotel, Toronto, Canada (118th)
1963 May 13-17, Ambassador Hotel, Los Angeles, Cal. (119th)

APA MENTAL HOSPITAL INSTITUTES

1961 Oct. 16-19, Sheraton-Fontenelle Hotel, Omaha, Neb. (13th)
1962 Sept. 24-27, Americana Hotel, Miami Beach, Fla. (14th)
1963 Sept. 23-26, Sheraton-Gibson Hotel, Cincinnati, Ohio (15th)
1964 Sept. 28-Oct. 1, Hotel to be announced, Boston, Mass. (16th)

OTHER APA MEETING

Divisional Meeting, September 21-23, Hotel Utah, Salt Lake City
Chairman: Dr. Myrick Pullen, Orofino, Idaho

CANADIAN MENTAL HEALTH SERVICES INSTITUTE

1962 January 15-18, Chateau Laurier Hotel, Ottawa, Ontario (2nd) (Inq. Dr. V. E. Chase, Canadian Psychiatric Assn., Suite 103, 225 Lisgar St., Ottawa 4, Ontario)

OTHER PROFESSIONAL MEETINGS

INTERNATIONAL CONGRESS OF PSYCHOTHERAPY, *August 21-26,* Vienna, Austria. (Inq. Dr. W. Speil, Lazarettgasse 14, Vienna 9, Austria.)

INTERNATIONAL CONGRESS OF GROUP PSYCHOTHERAPY, *August 24-27,* Paris, France. (Inq. Dr. W. J. Warner, P.O. Box 819, Grand Central Sta., New York 17, N.Y.)

WORLD FEDERATION FOR MENTAL HEALTH, International Congress on Mental Health, *August 30-September 5,* Paris, France. (Inq. Secretary General, WFMH, 19 Manchester Street, London W.1, England.)

AMERICAN PSYCHOLOGICAL ASSOCIATION, Annual Convention, *August 30-September 6,* New York, N.Y.

AMERICAN HOSPITAL ASSOCIATION, Annual Meeting, *September 25-28,* Atlantic City, N.J.

CANADIAN ASSOCIATION FOR RETARDED CHILDREN, Annual Meeting, *September 26-28,* Hotel Vancouver, Vancouver, B.C.

AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY, Examinations for certification in P&N, *October 9-10,* Chicago, Ill. (Inq. Dr. D. A. Boyd, Jr., Exec. Sec., 102-110 2nd Ave. S.W., Rochester, Minn.)

NATIONAL ASSOCIATION FOR RETARDED CHILDREN, Annual Convention, *October 11-14,* San Francisco, Cal.

ACADEMY OF PSYCHOSOMATIC MEDICINE, Annual Meeting, *October 12-14,* Emerson Hotel, Baltimore, Md. (Inq. Dr. G. Sutherland, Chm., 3700 N. Charles St., Baltimore, Md.)

AMERICAN SOCIETY OF MENTAL HOSPITAL BUSINESS ADMINISTRATORS, Annual Meeting, in conjunction with APA Mental Hospital Institute, *October 15-16,* Hotel Fontenelle, Omaha, Neb.

Melvin Mandel, M.D., of Pacific Palisades, has been elected president of the Board of Directors of The Westwood, a 50-bed psychiatric hospital in West Los Angeles.

Larc Ranch, a permanent home and school for the teen-aged and older mentally deficient, opened in June near Saugus. The facility is operated by the nonprofit Los Angeles Mentally Retarded Children's Foundation.

NEW YORK: The State Department of Mental Hygiene has announced the appointment of two acting directors. **Mrs. Annette C. Saunders** becomes head of the department's social services, and **John W. Schmidt,** in charge of the office of planning and procedures.

Stuart Gaul, New York attorney, has been elected president of the Mental Health Materials Center, Inc.—a non-profit educational organization for the publication and dissemination of authoritative literature in the areas of mental health, family life, and human relations. Mr. Gaul has served on the Center's Board of Directors since 1959.

Samuel Feinstein, M.D., has been appointed director of the new West Seneca State School in West Seneca. Dr. Feinstein was formerly assistant director in charge of the J. N. Adam State School Division at Gowanda State Hospital.

George E. Daniels, M.D., retired June 30 as director of the Psychoanalytic Clinic for Training and Research and as clinical professor of psychiatry, Columbia University's College of Physicians and Surgeons. Dr. Daniels is succeeded in both posts by **George S. Goldman, M.D.,** formerly associate clinical professor of psychiatry at the College of Physicians and Surgeons.

HERE & THERE: **John A. Trautman, M.D.,** formerly medical officer in charge of the U.S. Public Health Service Hospital, Ft. Worth, Tex., is now medical officer in charge of the USPHS Hospital in New Orleans, La. **Robert W. Rasor, M.D.,** formerly deputy medical officer of the USPHS Hospital in Ft. Worth, succeeded Dr. Trautman.

Reverend Ernest Bruder has been elected president-elect of the Association of Mental Hospital Chaplains. Chaplain Bruder is director of Protestant chaplain activities at Saint Elizabeths Hospital, Washington, D.C.

Robert B. Callahan, M.D., is the new director and psychiatrist of North Central Mental Health Clinic in Tiffin, Ohio. Dr. Callahan was formerly on the staff of Pennsylvania State Hospital.

Jesse L. Bollman, M.D., has been named director of research at Rochester State Hospital, Minn., and senior research consultant to the state department of public welfare. Dr. Bollman has been consultant and head of the section of experimental biochemistry at the Mayo Clinic.

Eric G. Carlson has been appointed executive director of the National Fund for Graduate Nursing Education, a privately supported, non-profit foundation working to solve the nation's nurse shortage.

Ernst Schmidhofer, M.D., became superintendent of State Hospital, Jamestown, N.D., on July 1. **Henry Lahaug,** former superintendent, has remained at the hospital as administrator.

Mrs. Lois Perry Jones, formerly of the APA Joint Information Service, is now working in the publications and reports section of the NIMH.

AWARDS: Arnold A. Schillinger, M.D., manager, **Veterans Administration Hospital, Northport, N.Y.,** received for the hospital the **National Grand Award** for the 1960 National Safety Contest, sponsored by the National Safety Council and the American Hospital Association. The hospital was also awarded the **VA Administrator's Safety Award** for the fifth consecutive year.